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ABSTRACT

A survey of consumer concerns of American Indians with disabilities in the Dallas-Fort Worth (Texas) area involved interviews with 150 American Indians with disabilities. Results are reported for the following areas: characteristics of respondents (sex, age, tribal identification, length of residence, income, disability, and experience with services); consumer concerns (such as availability of affordable health care insurance); and employment (45 percent were employed). Extensive tables provide detailed findings on tribal affiliations, specific impairments, services received in the past year, services needed in past year but not received, information needs, relative strengths and problems with services, and specific problems of respondents with alcohol or substance abuse problems. Results indicated that the two services wanted but not received by the largest number of respondents were dental care and help in finding or keeping a job. Affordability of health care insurance, assistive devices, and housing were other major concerns. Many respondents were unaware of the services available to them. Recommendations included formation of a community action plan, better publicity of available services, and services specifically targeted to young American Indians with disabilities. Extensive tables detail survey results. Appendices include numerous program administration materials. (Contains 10 references.) (DB)

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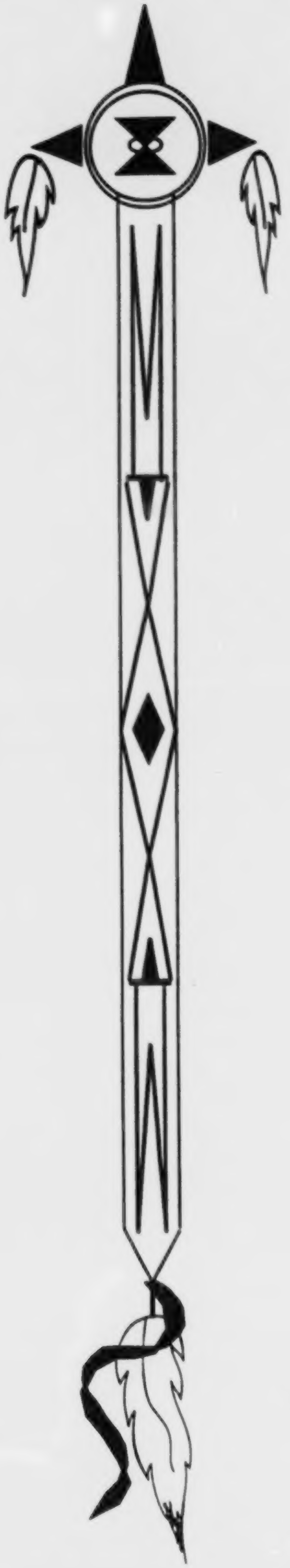

A NEEDS ASSESSMENT OF AMERICAN INDIANS WITH DISABILITIES IN THE DALLAS–FORT WORTH METROPLEX
FINAL REPORT: PHASE I

Revised
November 1993

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We hold our mouths in silence
Fear what should be said
Close our minds in sad remorse
Of changes that we dread

The past we cannot alter
The future lies ahead
This within our power
This fear we now can shed

Let your dreams fill the sky
No limits you can't reach
Hold on to our people's ways
Our children we can teach

Tell them of our past
Teach them of our ways
Learn from them our future
The children they will raise

Blending this together
We can make the call
Woven in our culture
Respect for one and all

When something's wrong … speak out
Say what must be said
The past we cannot alter
The future lies ahead

Mary Ann Frazier
© 5/20/92

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PREFACE TO THE NOVEMBER 1993 REVISED VERSION

Since this report was first circulated, new resources and the time to incorporate other material have led to many changes in the text. First, a previously unknown report on the Indians of Dallas (Goodner, 1969) was discovered. Material from this manuscript has been added to pages 4 and 71.

Second, a section on employment issues written mostly by Professor Ann Jordan, University of North Texas, has been added to the Introduction. Third, a map of the Dallas–Fort Worth metroplex and a series of appendices have been added. Fourth, references to the appendices have been inserted at appropriate places in the text. Finally, a few sentences have been updated with more recent information.

Robert M. Schacht

ACKNOWLEDGMENTS

Many people and organizations have contributed to making this research project a success. Catherine A. Marshall, Ph.D., developed this model for determining community-based needs of American Indians with disabilities through consumer involvement in Community Planning and Change in Denver and again in Minneapolis–St. Paul. The Texas Rehabilitation Commission (TRC) then took the initiative, inviting us to do a similar project in the Dallas–Fort Worth metroplex. They also took the initiative of working with the Dallas Inter-tribal Center and the American Indian Center (Grand Prairie) to prepare for this project before it officially began. Mr. Kenneth W. Vogel actively and capably coordinated this effort.

Mary Helen Deer Smith (Kiowa), executive director of the Dallas Inter-tribal Center, and Hilton Queton (Kiowa/Seminole), director of the American Indian Center in Grand Prairie, have contributed substantially to this project from the beginning. The Dallas Inter-tribal Center donated office and meeting space.

John O'Brien, head of the Dallas Southwest Field Office of the Texas Rehabilitation Commission, provided valuable office support and meeting space. Lori Kennedy (Osage), a VR counselor at the Southwest Field Office, provided valuable assistance in many ways. Sally Harris, a VR counselor at the North Field Office of the Texas Rehabilitation in Fort Worth, also provided important support.

Rev. Charles Battiest (Choctaw), and many other members of Dallas Indian United Methodist Church (DIUMC), provided valuable assistance throughout the project. Rev. Battiest is also a counselor at the Dallas Inter-tribal Center.

Pastor Dale Seigler and the people of Fort Worth Indian Baptist Mission provided meeting space and other forms of assistance for our project.

Frank McLemore (Cherokee), D/FW Employment Council for Persons with Disabilities, and Dallas Mayor's Council to Employ the Handicapped, gave us good advice, and obtained copies of important documents for us.

Peggy S. Larney (Choctaw), American Indian Education Program, Dallas Independent School District, participated in community meetings for the project and provided valuable information about American Indian children in the schools.

Gary Kodaseet (Kiowa), Aging Program Specialist, U.S. Department of Health and Human Services, Administration on Aging, participated as a speaker at the Dallas Interviewer Training Workshop and at the Dallas Community meeting.

Ann T. Jordan, University of North Texas, provided valuable information about the history of Native Americans in the Metroplex, some of which is used in the introduction.

This project could not have succeeded without the guidance and assistance of the members of the working group, who decided which consumer concerns should be addressed in the survey and how each concerns statement should be worded. Some of these people subsequently were trained and worked as interviewers for this project. We thank the members of both groups for their important contributions: W. Edward Pisachubbe (Choctaw), Rena Goings (Choctaw), Lori Frazier (Choctaw), Mary Harkins (Choctaw), Darrel James (Choctaw), Gerald Jimmy (Western Shoshone), Alex Palmer (Seminole), Anna Jo Spotted Bear (Choctaw), Bernadine Tiger (Sioux), Renita Chalepah (Sioux), Carl Osage (Iowa/Osage), Devon Baptiste (Choctaw), Gilmore Williams (Chickasaw/Choctaw), Madeline Jessie (Choctaw), Julius Taylor (Choctaw), Liz Taylor (Choctaw), Fannie LaSarge (Choctaw), Juanita Kicinski (Choctaw), Olivia Longoria (Choctaw), Lyndon Johnson (Choctaw), Timothy Tubby (Choctaw), Eldeen Anne Peña (Creek/Seminole), Betty Pahcheka (Comanche), Julia Pahcheka (Comanche), Randall Burgess (Creek/Cherokee), Flo and Hubert Emhoolah (Kiowa), and Victoria Folsom (Choctaw). We also are especially grateful to all the respondents who took the time to share with us their experiences. The central goal of this project is that, as a result of the information they gave us, the functional capacity and quality of life of American Indians with disabilities living in the Dallas–Fort Worth metroplex will be improved.

INTRODUCTION

On August 15, 1990, Mr. James L. Jackson, executive deputy commissioner for the Texas Rehabilitation Commission, requested the assistance of the American Indian Rehabilitation Research and Training Center (AIRRTC) to do a research analysis of the American Indians in Dallas. Dallas was chosen because Mr. Jackson identified it as having the largest concentration of American Indians of any reservation or city in the state.

In particular, Mr. Jackson asked that the study provide information concerning :

1. The number of American Indians residing in Dallas
2. The tribes represented by the American Indian population
3. The location within Dallas of the American Indians
4. The number of American Indians with disabilities in Dallas
5. The nature of the disabilities of the American Indians
6. What services are the American Indians receiving
7. At what locations do they socialize
8. Where are medical services being rendered

Accordingly, the AIRRTC submitted a proposal for funds for this purpose in its next continuation application. This application was for projects for the 1991-1992 fiscal year, beginning in September 1991

The Texas Rehabilitation Commission did more than ask for the project to be done. It also agreed to support the project by paying the salary of an on–site research coordinator and assigned Mr. Kenneth Vogel to represent the TRC. Mr. Vogel met with members of the Dallas Indian community before the project began to help get the project started as soon as possible.

The AIRRTC at that time was finishing a research analysis of this kind in the Denver area (Marshall, Johnson, Martin, & Saravanabhavan, 1990). It was also preparing to do a similar project in Minneapolis, which has now been finished (Marshall, Day-Davila, & Mackin, 1992). In these two projects, the research methodology had been successfully developed and tested. A two-year follow-up to the Denver study is planned for 1992-3 to assess the impact of the project.

The American Indian population in the Dallas–Fort Worth metroplex, however, is different in several respects. In particular, the diversity of tribes differs from Denver (predominantly Sioux) and Minneapolis (predominantly Chippewa or Ojibway); in Dallas, the largest group has been identified as Choctaw (McClure & Taylor, 1973). Furthermore, in the previous studies, a large majority of the respondents were from one tribe (Denver: 67% Sioux; Minneapolis: 80% Chippewa or Ojibway.) In Dallas, however, the most numerous tribe (Choctaw) was a minority of the American Indians.

American Indians in the Metroplex

Information on American Indians in the Dallas–Fort Worth metroplex (Figure 2) is described by Goodner (1969), McClure and Taylor (1973), and Jordan (1991). Few Indians lived in the metroplex prior to the implementation of the Bureau of Indian Affairs' Relocation Program in the 1950s. In 1950 the Census Bureau counted only 163 American Indians in Dallas and Tarrant Counties (Census Bureau, Dallas field office, p.c.).

In 1957 the BIA opened a Field Employment Assistance Office in Dallas. During the ensuing 16 years, the BIA relocated over 10,000 Indians to the Dallas–Fort Worth area. For example, from 1952 to 1960, 265 Navajos were relocated to Dallas (Young, 1961, p. 238). The Bureau of the Census recorded 1,032 American Indians in Dallas and Tarrant Counties in 1960 and 5,022 in 1970. In 1972, 54% of the American Indians in a sample of 1,260 family units considered Oklahoma as their Family Home State, while about 20% named Arizona or New Mexico (McClure & Taylor, 1973, p. 15).

Although the Relocation Program was terminated in 1973, the urban migration continued. From 1970 to 1990, the American Indian population of the metroplex grew from 5,022 to 18,972 (Figure 1). This implies a growth rate of about 700 per year over the past 20 years.

Figure 1. American Indian Population of Dallas MSA

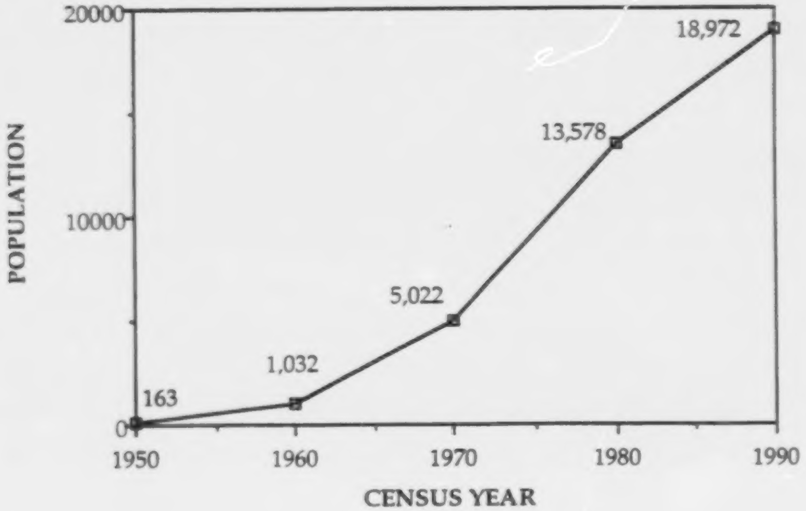
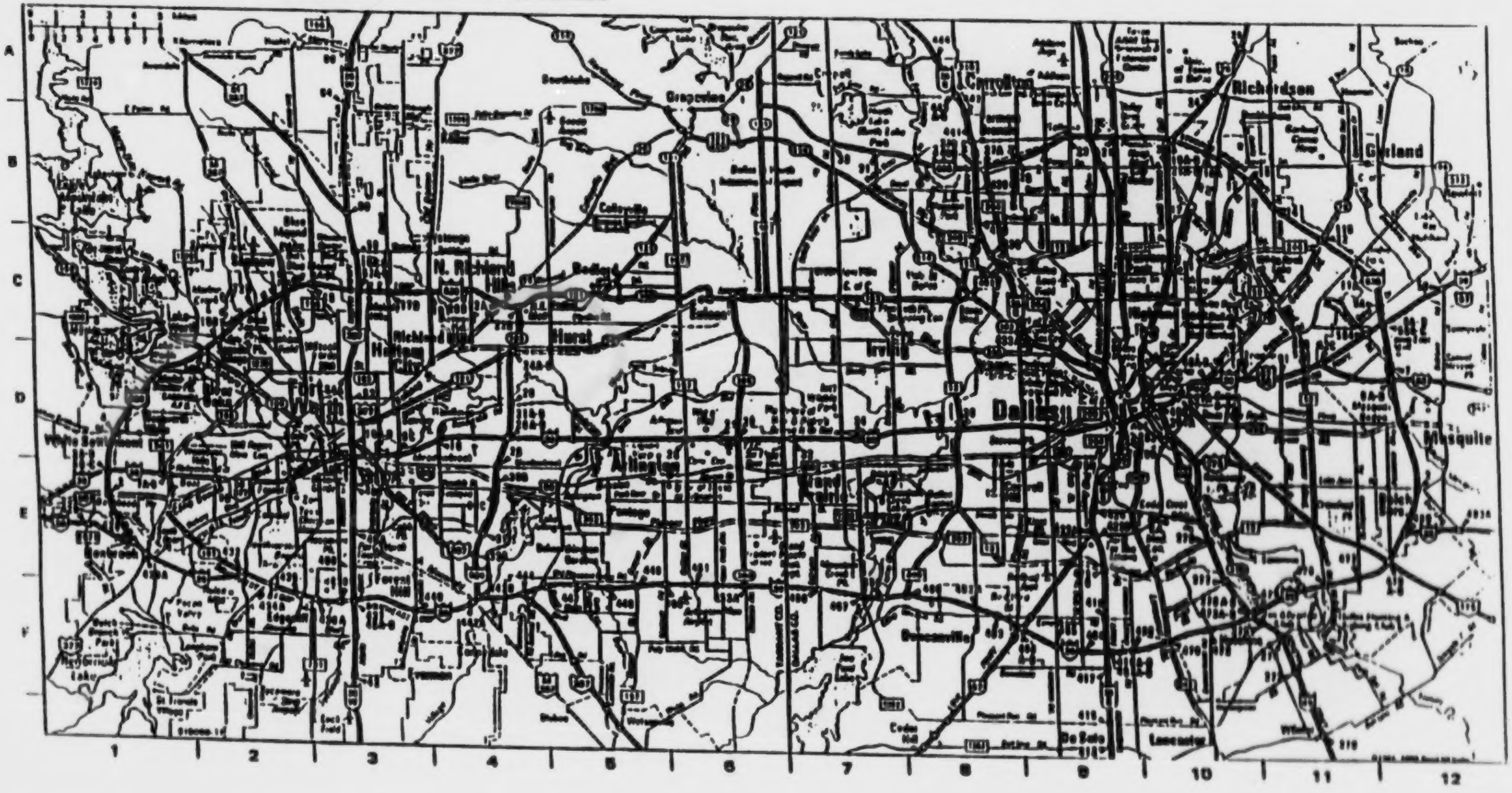


Figure 2: The Dallas-Ft. Worth Metroplex



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According to the U.S. 1990 census, of the total American Indian population in the metroplex, about 50% are in Dallas County (Figure 2, AF1-6), 25% in Tarrant County (Fort Worth) (Figure 2, AF7-12), and the remainder in smaller surrounding counties (such as Denton and Collin). In the metroplex, the city of Dallas has the largest American Indian population (1990: 4,792). Fort Worth, Arlington (Figure 2, DE5-6), and Irving (Figure 2, CD7-8) each has more than 1,000 American Indians. However, this population is scattered over the entire metroplex. Twenty-five cities and towns in the metroplex have a population of at least 100 American Indians, and in each of these the American Indian population is less than 1% of the total population.

Only in a few neighborhoods (defined by census tracts or block groups) of Dallas are there more than 100 American Indians. One of these concentrations was in West Dallas in census tract 101.02, where there were 197 American Indians (5.4% of the population). This tract is north of Singleton Boulevard extending for half a mile or so on either side of Sylvan Avenue (Figure 2, D9). It is the east end of ZIP code 75212. Block Group 2, a subdivision of Tract 101.02, had the highest concentration of American Indians (10% of the population, 163 American Indians). Another concentration was in Tract 42, where 116 American Indians constituted 1.44% of the population. This tract is located in Oak Cliff in ZIP code 75208 around Kidd Springs Park (Figure 2, E9), where regular pow wows are held. There are only a few other tracts where American Indians were 1-2% of the population (Table 1). In the rest of the metroplex, the American Indian population was scattered throughout these cities in small numbers (that is, less than 1% of the population of the neighborhood). Goodner (1969, p. 20) explains this dispersed settlement as follows:

> The Indians of Dallas, unlike many minority groups, do not seem to desire to live in one particular neighborhood after they have become accustomed to the city. Instead they seem to move into locales which meet their own tastes and economic capacities. This does not mean that there is an avoidance of close living with other Indians, for often two or three families buy homes within a short distance of each other.

Table 1

Summary of Addresses Given by Interviewees

County	City/ZIP	American Indian population (1990)	AIRRTC interviews (1992)	McClure & Taylor families (1973)
Dallas	Dallas	4,792	86	1,260
	75211		(26)	(100+)
	75214		(16)	(75-99)
	75208		(11)	(100+)
	75203		(6)	(50-74)
	75224		(3)	(25-49)
	75204		(1)	(75-99)
	75206		(1)	(25-49)
	75232		(1)	(25-49)
	Irving	1,006	6	
	Garland	954	3	
	Grand Prairie (incl. AIC)	774	15	
	Mesquite	557	2	
	Carrollton	348		
	Richardson	239		
	Farmer's Branch	158	1	
	Other places	125	1	
Dallas Total, all places		9,437	114	
Tarrant	Fort Worth	1,914	19	
	76110		(4)	
	76135		(3)	
	Arlington	1,323	1	
	Haltom City	242	5	
	North Richland Hills	236		
	Euless	211		
	Hurst	155		
	Other places	134	1	
Tarrant Total, all places		5,551	26	
Other Metro places 2,528			1	
Total Metro (Dallas, Tarrant, & other)		17,516	141	
Other Texas			1	
Other states (Oklahoma, New Mexico)			8	
			150	

The American Indian population of the metroplex has not always been so dispersed. McClure and Taylor (1973) reported a concentration of 100 families or more in ZIP code areas 75211 and 75208 in Southwest Dallas (Oak Cliff) (Figure 2, E9). Concentrations of 75-99 families were reported in ZIP codes 75214 and 75204 (between I-75 and White Rock Lake) (Figure 2, C10). It may be that the American Indian population of the metroplex is becoming more dispersed through time.

The most numerous tribe represented in the metroplex is the Choctaw, representing about one third of the American Indian population. Surveys differ as to which other tribes are most numerous. The Cherokee, Creek, Navajo, and Sioux are usually listed among the seven most numerous tribes, ranging from about 16% down to about 4%, depending on the survey. Other tribes such as the Kiowa, Comanche, Potowatomi, or Seminole are sometimes ranked among the tribes with the largest population in the metroplex, ranging up to 12% in some surveys (McClure & Taylor, 1973; Larney, 1992; Smith, 1992).

There are a number of places where the American Indians in the metroplex come together. The Dallas Inter-tribal Center (Figure 2, D9) has the only Indian Health Service clinic in the metroplex. It also has offices for WIC, JTPA, and many other services. The American Indian Center in Grand Prairie (Figure 2, E7) has a treatment center for American Indians with substance abuse problems. Two principal settings are the pow wows and the churches. There are at least five such churches in the metroplex: Dallas Indian United Methodist Church; First Indian Baptist Church; Dallas Indian Revival Center; Fort Worth Indian Baptist Mission, and Heritage Assembly of God (Ft. Worth). Pow wows are held at a number of places, perhaps the most important of which has been Kidd Springs Park in Oak Cliff in Southwest Dallas. Facilities for such team sports as softball and bowling are another important kind of gathering place (McClure & Taylor, 1973, pp. 8, 9, 19).

Employment Issues

Native Americans come to the metroplex looking for work. In some instances this is displayed as a desire to get education or job-related training; in others it is a direct result of the high unemployment rate back home. If home was a reservation, typically there are not enough jobs available. If home was Oklahoma, unemployment in the rural Native American communities has chronically been high. As a result of the 1980s oil crisis, Oklahoma rural and urban areas alike experienced economic depression and high unemployment. In the 1980s many migrants to the metroplex were members of Oklahoma tribes who had been working in Tulsa or Oklahoma City and had been forced to move on due to the economic difficulties there.

Native Americans seem to fare less well in the city than at home. In 1980, when unemployment for the metroplex as a whole stood at 5.4%, it was 45.6% for Native Americans. Median family income was $25,800 for the general population and $7,000 for Native Americans. These statistics are all the more striking when one considers that the difference in median education level between the two groups is not that great, averaging 12.7 years for the general population, and 11.2 for Native Americans. Additionally, 53% of the Native Americans lived at or below the poverty level while only 4% of the general population did. In 1989, according to the U.S. Census, 1,026 (21%) out of a sample of 4,979 American Indians 18 to 64 years old had an income below the poverty level (1990 Census, STF3C). The plight of urban Indians in Texas compares negatively with their reservation counterparts. Unemployment on the Tigua and Alabama/Coushatta Reservations was at 36% and 37% respectively (Texas Indian Commission 1984, p. 10). Thus reservation Indians in Texas have fared better in the unemployment statistics than have their urban neighbors.

Information collected in 1972 indicated that most Dallas Indians were employed as manual laborers (31.5%) or as clerical workers (19.3%). Only a handful were self-employed (less than 1%) or supervised one or more persons on the job (12%) (McClure and Taylor, pp. 24-25). Ten percent, however, had professional jobs. Current information suggests that little has changed since that time. The Dallas Intertribal Center (DIC) has government funding to assist Native Americans in finding employment. For qualified individuals, the DIC can assist by providing tools, bus passes or actual job training at one of several technical schools in the area. It is clear, however, that this program is hardly able to make a dent in the unemployment statistics. During the reporting year ending in June 1990, the center assisted 132 individuals in the job search. Of the 88 individuals terminated in the program, 54 (67%) entered employment and 22 more were positively terminated into training or education programs. These 88 individuals provide a portrait of the Native American job seeker. Fifty-nine percent were female, 24% were 16-21 years of age, and 69% were 22-44 years of age. Twenty-eight percent were single head of household with dependent children. Forty-nine percent were school dropouts. Eighteen percent were on welfare, and 8% were transients. Their average earning in the year before their enrollment in the program was $4,756 and their average hourly wage at termination was $5.

Although there are several reasons for the high unemployment, inadequate job skills is the primary one. For the most part, Native Americans migrating to the metroplex possess job skills and experience in manual labor, and few of those jobs are available. They posses the wrong skills for the job market, and with less than a high school education, they are unable to adapt easily.

There are other reasons for this high unemployment rate. Sixty percent of those looking for work are women, and many of them are single parents who had their first child at the age of 14 or 15 and have, again, less than a high school education. Other than the lack of job skills mentioned above, they face the added problem of child care. Transportation poses a third problem. Public transportation is limited to a bus system that is a slow and inefficient means of travel. If one does not have access to an automobile, it is extremely difficult to get back and forth to work in most sections of the city. Many urban Indians do not have the financial means to own a vehicle. Also, those recently moving from rural or reservation areas find this difficult bus system overwhelming and do not understand how to navigate these large, sprawling cities on the bus.

Transients comprise 8% of the Native Americans seeking employment assistance. In the late 1980s, this figure was 25%. The large number of transients has been due to a great extent to the depressed economy of Oklahoma, as Native Americans laid off in Tulsa and Oklahoma City move to Dallas. Typically, they are without housing or transportation. Their job experience is in odd jobs, often in construction. They range in age from 25 to 47. They cannot get housing without a job, and they cannot get a job without two years' previous experience in a single job. Native Americans in this situation return to their homeland or end up on the streets as part of the metroplex's growing street population.

Another reason for the difficulty in acquiring employment is the difference in Native American communication skills. In order to assist in this, the Dallas Inter-tribal Center holds interview-skills training sessions to teach newcomers how to communicate with non-Indians. Native American behavior of averting the eyes and responding in monosyllables appear to most Texans, including future employers during job interviews, to indicate a lack of assertiveness and a lack of communication skills, rather than a culturally different set of communication skills.

Native Americans coming to the metroplex often have poorly developed skills for finding jobs and poorly developed strategies for economic survival in the city. Unemployment is extremely high and annual incomes extremely low. While there are some notable exceptions, Native Americans have had little success in tapping into the "good ol' boy" economic networks in the metroplex.

Native American leaders are attempting to change this. In 1987 an American Indian Chamber of Commerce was established in Dallas. In 1991 the chamber had approximately one hundred members and was aware of approximately one hundred Native-American-owned businesses. Most were service businesses like construction, accounting, and environmental testing. A few were manufacturing businesses. Most were small, sole proprietorships facing the common problems of a small business. Through the chamber they are attempting to help on another and to make inroads into the larger economic structure though their relationship with other local chambers. Despite the chamber of commerce and the economic success of a few, these business owners are not visible in the Native American community, and it appears that for many Indians the metroplex provides little improvement in economic conditions over their rural homelands.

METHODOLOGY

Preparations

The research methodology for this project was based on the consumer concerns method developed at the University of Kansas (Fawcett, Suarez de Balcazar, Johnson, Whang-Ramos, Seekins, & Bradford, 1987). The consumer concerns method was expanded by the addition of questions on general information about the consumer, disability information, services information, educational information, social information, and employment information.

Research Design. At the heart of this research method is the conviction that consumers should be involved in the entire project, from deciding what questions should be asked to interpreting the results. In particular, there are three major points of consumer involvement, according to the consumer concerns method: (a) a working group of 6 to 8 consumers with representative disabilities, (b) a concerns survey, and (c) a community meeting at which results of the survey are presented. The members of the working group are asked to help select the concerns to be included in the concerns survey.

On-site Research Coordinator. In addition, following the work of Marshall, Johnson, Martin, and Saravanabhavan (1990) and Marshall, Day-Davila, and Mackin (1992), an on-site research coordinator and a group of interviewers were recruited from the American Indian community in the Dallas metro area. To accelerate the process, the on-site research coordinator was hired full-time for four months rather than half-time for eight months. Accordingly, flyers announcing the on-site research coordinator position (Appendix A) and information about the project were circulated in September 1991.

Preliminary Meetings. Even before the project formally began, the Texas Rehabilitation Commission initiated several meetings with the directors of the Indian centers (DIC & AIC) in Dallas County to enlist their support for the project. Once the project formally began at the end of September 1991, a series of preliminary meetings were held September 30, October 21, and November 13-14, 1991, in Dallas at the Dallas Inter-tribal Center (Appendix B). During the first two meetings, the project was described to members of the American Indian community and the importance of gathering a working group of consumers with representative disabilities was emphasized. Information about the on-site research coordinator position was discussed, as well as information about the interviewer positions (Appendix C). It was announced that these interviewers would be paid $25 for each interview and that interviewers would be required to attend a three-day training workshop. Interviewees would be paid $20.

Recruiting an On-site Research Coordinator. Before and after the first meeting, candidates for the position of on-site research coordinator were interviewed by Robert Schacht (the project director), Ken Vogel (Texas Rehabilitation Commission), Mary Helen Deer Smith (director, Dallas Inter-tribal Center), and Hilton Queton (director, American Indian Center, Grand Prairie). This group served informally as an advisory committee to the project.

Ron Hickman (Choctaw) was selected by the advisory committee as on-site research coordinator and officially was hired by the Texas Rehabilitation Commission and began working on the project just before the October 21 meeting. During this meeting, it was decided that a working group meeting would be held on November 13 and 14, 1991, at the Dallas Inter-tribal Center. One of the on-site research coordinator's first major tasks was to recruit six to eight American Indians with disabilities for this working group meeting.

The Working Group. To recruit consumers for the meeting, the Dallas Inter-tribal Center, American Indian Center, Dallas Indian United Methodist Church, Texas Rehabilitation Commission, Dallas Independent School District, U.S. Office of Personnel Management, and other individuals were contacted to help with the identification of American Indians with disabilities to participate in the development of the survey instrument.

To be accepted by the Native American community and gain credibility for the project activities, a door-to-door campaign was implemented by the on-site research coordinator. During these visits, 15 to 20 minutes were devoted to getting acquainted with each household member, sharing information about the survey, recruiting persons for the working group meeting and interviewer training, and talking about food for a potluck dinner. A flyer about the project was left with each household. In addition, flyers were disseminated at community organizations and churches and a public announcement was recorded on the American Indian Center's telephone message system.

The resulting working group met on November 13 and 14 to develop the concerns survey. It consisted of 21 American Indians: 19 from Dallas County and two from Tarrant County. After defining and discussing the concept of disability (Appendix F), five of these reported a disability of their own, and seven others reported that they had a disabled family member. During the meeting, it was discovered that the door-to-door campaign attracted the majority of the consumers, while others had heard about the meeting or read the flyers.

The working group considered a total of 41 statements used in the Denver and Minneapolis projects. Of these, eight were deleted or combined with another statement. Two statements were added, and 12 were reworded. A vote was taken on each statement as to whether to retain it, reword it, or delete it. Statements receiving less than 50% of the vote were deleted or combined with statements for which there was more support. Statements with weak support (50% to 70%) were discussed at length and often reworded.

The result was 35 consumer concern statements, each in the form specified by the University of Kansas method that is:

1. Each item is phrased as a positive statement (e.g., "You feel safe" rather than, "You don't feel safe").
2. Use of the second person (e.g., "You feel safe" rather than "I feel safe" or "We feel safe") is necessary for the way in which the statements are presented on the survey.
3. All items are expressed in the form of simple statements rather than questions (e.g., "You feel safe" rather than "Do you feel safe?").

It was difficult for some consumers to understand why it was necessary for statements to be worded this way and led to the perception by some that the researchers were not really listening to them. This aspect of the methodology may need to be reconsidered or more clearly explained in future projects.

The questions in the sections other than the consumer concerns part were borrowed from the interview instruments developed for the Denver and Minneapolis studies and adapted to the needs of service providers in the Dallas–Fort Worth metroplex.

Meanwhile, the on–site research coordinator was developing a master list of potential interviewees from a newsletter mailing list supplied by the Dallas Inter-tribal Center, as well as names and addresses acquired from other Indian organizations and churches and from people responding to flyers and other publicity releases. These were sorted and typed according to their ZIP codes.

At the same time, brochures, booklets and other information were collected from service providers. These materials included information about their current services and benefits for a person with a disability, to distribute to interviewees during the interviews.

Pilot Training

The research design called for the on–site research coordinator and one additional interviewer to be recruited to travel to Northern Arizona University in December for three days of interview training. Recruitment efforts for this additional interviewer took place during the door-to-door campaign used to recruit members of the working group. In addition, all persons attending the working group meeting were invited to apply for this position.

After the working group meeting on November 14, the principal investigator and the on–site research coordinator interviewed 11 persons for this pilot training. The on–site research coordinator scheduled appointments for the following week with candidates who could not stay after the meeting. After these interviewers, a candidate was selected to accompany the on–site research coordinator to Northern Arizona University for the pilot interview training.

However, two days prior to the departure for the training, this candidate decided to withdraw from the project, because she had been hired for a full-time position. To recruit a replacement, all of the applicants were reviewed again. During this review process, another applicant, Darrel James (Choctaw), was interviewed. He was selected because of his excellent communication and writing skills, his knowledge of Indians in the community, and his willingness to make a commitment to work with the on–site research coordinator for the duration of the project.

For the pilot interview training at Northern Arizona University (Appendix E), an *interviewer manual* developed for the Denver and Minneapolis projects was adapted and used. Ron Hickman, the on–site research coordinator, and Darrel James were briefed in detail on all aspects of the project and practiced their interviewing techniques on one other. Then, to simulate more closely an actual interview situation, Darrel James interviewed Marie Johnson (Navajo), an elderly resident of Flagstaff with an orthopedic disability, while Ron Hickman and Bob Schacht observed. To further refine their skills, both trainees conducted videotaped interviews with Franklin Halwood (Navajo), an AIRRTC employee who has quadriplegia and uses a wheelchair. During the pilot training, the trainees recommended additional changes in both the survey instrument and the *interviewer manual*, which were revised accordingly.

After completing their training, Darrel James and the on–site research coordinator returned to Dallas in order to pilot-test the survey instrument with ten American Indians living in the metroplex who have a disability. Two additional consumer concern statements were field-tested upon the recommendation of a consultant. After reviewing these new items with the respondents, the on–site research coordinator recommended that the items should be added, and the survey instrument was revised accordingly.

Whenever possible, pilot test interviews were preceded by a telephone contact in which the purpose of the survey was briefly explained and permission to interview was obtained. The interviews were held at various locations, such as the Dallas Inter-tribal Center, the Dallas Indian United Methodist Church, the Yellow Rose Shelter, and in their homes. Interviews were usually conducted directly with the person with the disability. In cases where a direct interview was prohibited by the disabled person's health or age, the survey was assisted by a primary caretaker.

All ten persons who were interviewed expressed their appreciation for the survey and the need for such a survey. Their comments included remarks such as "We are glad that someone has taken an interest in the American Indians in Dallas," and "I hope this survey will help our people who are disabled."

During Mr. Darrel James' first interview in Dallas, supervised by Mr. Ron Hickman, they discovered that the respondent spoke mostly Choctaw. This meant that they had to interpret parts of the questionnaire into Choctaw.

At the conclusion of the pilot interviews, the survey instrument was reviewed and approved for use, with the addition of the two additional consumer concern statements. This made it possible to proceed with plans for recruiting and training more interviewers.

Interviewer Training

Interviewers were recruited by the dissemination of flyers (Appendix C) beginning in September 1991, by announcements at the first two community meetings (September 30 and October 21), and at the working group meetings (November 13 and 14), during the door-to-door campaign, and during the pilot test interviews. Once this recruitment process was under way, people responded with telephone calls, and others came to the Dallas Inter-tribal Center for more information about the three-day training.

To recruit interviewers from Fort Worth, in addition to the above recruitment methods, Sally Harris, VR Counselor, and the on–site research coordinator made a presentation at the Fort Worth Indian Baptist Church. Other presentations were made in Dallas at the American Indian Center, the Dallas Indian United Methodist Church, and the Dallas Independent School District. Prior to the three-day training, individuals who were interested in the training were recontacted by telephone calls and by personal visits in their homes.

Two interviewer training workshops were held: one, on January 16-18, 1992, was held at the Dallas Inter-tribal Center; the other was held a few days later in Fort Worth at the Texas Rehabilitation Commission Field Office (January 20) and the Fort Worth Indian Baptist Mission (January 21-22). The principal trainer for the workshop in Dallas was Charlene Day-Davila (Ojibway), on–site coordinator for the Minneapolis project, assisted by Ron Hickman and Bob Schacht. The workshop schedule was similar to that used for the pilot training at NAU, with the addition of presentations by local American Indian service providers such as Charles Battiest (Choctaw; counselor, DIC); Gary Kodaseet (Kiowa; aging program specialist, U.S. Dept. of Health and Human Services), Lauro Guerra (program specialist, Administration on Developmental Disabilities), and Lori Kennedy (Osage; VR counselor, Texas Rehabilitation Commission). Thirteen trainees attended this workshop, twelve attending all three days.

In Fort Worth, the training was conducted by Schacht, Hickman, and Sally Harris (VR Counselor). There were three trainees on the first day, of whom two completed all three days. As a result of these three training workshops in Dallas, Fort Worth, and Flagstaff, 15 people completed all three days of training.

Interviewer Characteristics. A total of 17 interviewers were trained for this project, including the on–site research coordinator. Two others began the training but did not finish. Of those who completed the training, 14 completed at least two interviews. Seven were women, and seven were men. Two lived in Tarrant County and were trained in Fort Worth. They did most of the interviews in Tarrant County. One lived between the two cities and did some interviews in Tarrant County, and some in Dallas County. Five of the interviewers lived in Dallas; three lived in Grand Prairie; two lived in Mesquite; one in Garland and one in Rowlett. In terms of tribal affiliation, eight were Choctaw, one was Kiowa, one was Seminole, one was Western Shoshone, and two had a mixed tribal ancestry. They ranged in age from 23 to 57. Four had a disability, and another had a family member who has a disability.

Conducting the Survey

The on–site research coordinator was responsible for local supervision of the survey. This included recruiting people to be interviewed; giving interviewers the names, addresses and telephone numbers of people to interview; overseeing the first interview of each interviewer; providing resources for the interviewers; managing the work loads of the interviewers; verifying a sample of the interviews; processing contact logs and billing statements, and routing the completed questionnaires and other paperwork to the project director at Northern Arizona University for processing.

Recruiting Interviewees. The first task in conducting the survey itself was to find American Indians with disabilities in the metroplex who wanted to be interviewed. This process had begun earlier, with the circulation of flyers in September 1991. These flyers (Appendix D) mentioned that interviewees would be paid $20 for the completed interview. During the first two preliminary meetings, similar announcements were made inviting American Indians with disabilities to let us know if they wanted to be interviewed. This process was accelerated during the door-to-door campaign conducted by the on–site research coordinator while preparations were being made for the working group meeting.

In order to reach more of the Indian community, the on–site research coordinator and Lori Kennedy (VR Counselor, Texas Rehabilitation Commission) were granted a 20-minute public service announcement on radio station KNON's "Beyond Bows and Arrows" program. The American Indian Center recorded two public announcements on their telephone message system. The Dallas Inter-tribal Center devoted a full page of their quarterly newsletter, *Smoke Signal*, to information about the project, including an invitation to be interviewed. Approximately 300 flyers were disseminated at community organizations, churches, pow wows, and personal contacts. In addition, letters describing the survey were sent with recruitment flyers to 140 organizations in the metroplex that served people with disabilities. We asked the staff of these organizations to help us to bring the information about the survey to the attention of any American Indians who had a disability or who might know someone who might be interested.

The most effective method of recruiting interviewees was the door-to-door campaign. This method provided an opportunity to establish rapport and explain the purpose of the study. As a result of this method, the Indian people saw the need for the survey and began providing names and addresses of American Indians with disabilities whom they knew who might be willing to be interviewed.

In addition, one of the last questions asked during each interview was, "Do you know anyone who has a disability that we might also interview?" If the response was "yes," the interviewer asked for the name, address, telephone number, best time to call, and age of the person. This also produced many leads.

Interview Assignments. The on–site coordinator usually would assign an interviewee to the closest available interviewer. At the beginning of the project, each interviewer was given three questionnaires. After the first set of interviews, each interviewer was issued five to ten additional questionnaires. In Dallas, the interviewers came to the on–site coordinator's office to pick up the questionnaires. In Fort Worth, the questionnaires were delivered to the interviewers.

The First Interview. The on–site coordinator's responsibilities included overseeing each interviewer's first interview. For some interviewers, their first interview may be accompanied by anxiety. The on–site coordinator's presence can help ease those anxieties. The on–site coordinator acts mainly as an observer, to see if the interviewers are sufficiently comfortable with the interview process to proceed with additional interviews on their own.

Resources. We anticipated that some interviewees may not be familiar with services for which they might be eligible. To help them learn about other resources in their communities, each interviewer was equipped with a set of brochures and booklets for the Dallas Inter-tribal Center, the American Indian Center in Grand Prairie, the Texas Rehabilitation Commission, and the Social Security Administration. Business cards for VR counselors with special responsibilities for outreach to the American Indian community (Lori Kennedy [Osage] in Dallas; Sally Harris in Fort Worth) were attached to the Texas Rehabilitation Commission brochures, and interviewees were encouraged to call these contacts with any questions they might have about services. Many interviewees did not know about these services.

Work Load. The work load varied from one interviewer to another depending on the number of hours and days each interviewer could spend interviewing and on the number of persons to interview in his or her area. During the interview process, most of the interviewers were seeking full-time employment; some were enrolling in community colleges; and others were working at part-time jobs. When each interviewer called the on–site coordinator's office, the on–site coordinator would find out how many hours or days he or she would be available for interviewing. This helped the on–site coordinator to determine the amount of work each interviewer could do. Sometimes health problems, travel, or other situations made an interviewer temporarily unavailable for work. As a result, the available pool of interviewers often changed from one week to the next.

The interviewers mailed or brought their completed interviews to the on–site coordinator's office. Whenever possible, the interviewer and on–site research coordinator double-checked the contact logs, billing statements, etc., before mailing them to NAU for processing and data entry. If the contact logs or billing statements, etc., were not signed or were left blank, the interviewer and/or interviewee was contacted to sign the billing statements or complete the interview.

Billing and Data Entry. At Northern Arizona University, the billing forms and contact logs were processed and checks sent to the interviewees and interviewers. The data from the questionnaires was then entered into a computer for analysis.

Community Concerns Report. A one-page summary of the demographic data was copied and attached to a copy of the consumer concerns section of each questionnaire. This data was sent to Barbara Bradford Knowlen, AIRRTC consultant, to prepare a community concerns report. In this report, importance and rating scores were calculated for each item for the 150 respondents and for many subgroupings of respondents. These scores are based on the average responses, scaled to a range of 0 to 100. The 37 items in this section were then listed for each group or subgroup in order of "relative strengths," which are relatively high in both importance and satisfaction, and "relative problems," which are high in importance but low in satisfaction.

RESULTS

From January to June 1992, a team of 14 interviewers interviewed 150 American Indians with disabilities in the Dallas–Fort Worth metroplex. Of these, 114 lived in Dallas County, 26 live in Tarrant County, and 10 gave addresses in nearby counties or neighboring states (Table 1). Many in this last group were interviewed at the American Indian Center in Grand Prairie and were living there temporarily.

Throughout the interviewing period, the interviewers discovered that many American Indians didn't know anything about many of the services and benefits that are available for a person with a disability. As a result, much information about these services was disseminated by the interviewers in the form of brochures from the Texas Rehabilitation Commission, the Dallas Inter-tribal Center, the American Indian Center in Grand Prairie, the Social Security Administration, and other publicity sources.

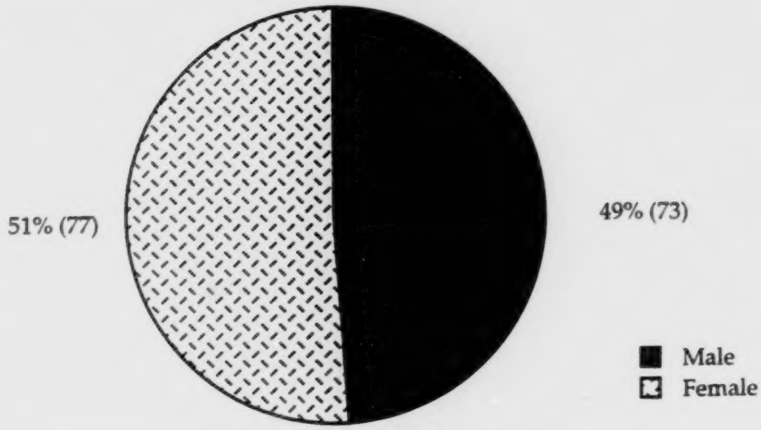
Another immediate result was that after the project had begun, the Dallas field office of the Texas Rehabilitation Commission identified one of its VR counselors, Lori Kennedy, as an American Indian (Osage) and beginning in January 1992, gave her special responsibilities for serving American Indian clients. As the project progressed, many interviewees contacted her for information, referral, or applications. In the Fort Worth field office, Sally Harris, the VR counselor with special responsibilities for American Indian clients, experienced a similar increase in her American Indian caseload.

The interviews took an average of 82 minutes (standard deviation: 22 minutes). Most took place in the interviewee's home, but 29 were conducted at the Dallas Intertribal Center, nine were conducted at the American Indian Center in Grand Prairie, and more were conducted at other places.

General Information about Respondents

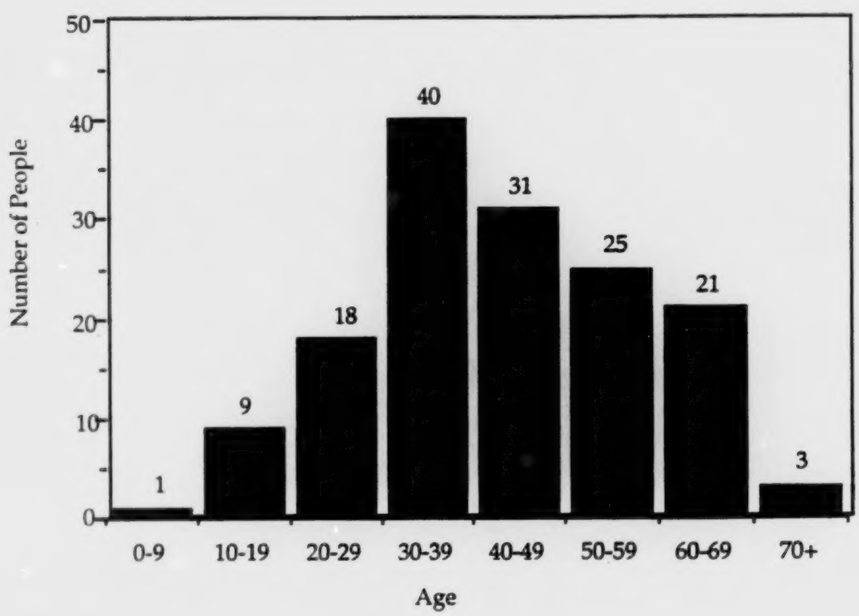
Sex. The interviews were divided almost evenly: 73 (49%) were male, and 77 (51%) were female (See Figure 3).

Figure 3. Sex of Interviewees



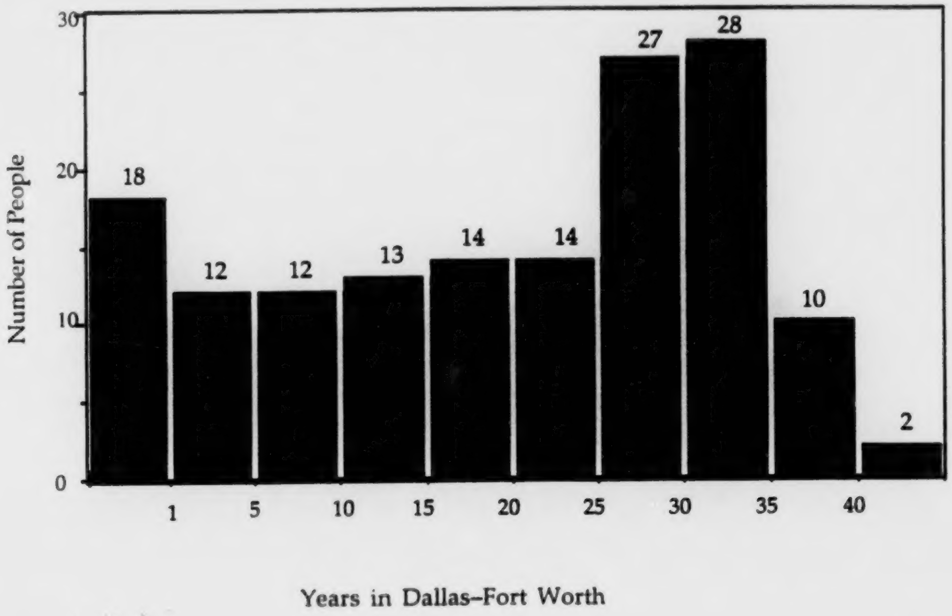
Age. Most of those interviewed were adults (Figure 3); but we interviewed the mother of a seven-year-old boy who had a disability, as well as nine teenagers. This means that 5% of those interviewed were school age (5 to 18 years old). Respondents less than 30 years old constituted 19% of the sample. The average age was about 42. Most of the respondents (61%) were 30 to 54 years old. Respondents 55 years of age or more were 20% of the sample. The oldest person we interviewed was 81 years old.

Figure 4. Ages of People Interviewed



Length of Residence. Most of those we interviewed had lived in the Dallas–Fort Worth area for at least 10 years (Figure 4.) However, there were 18 who had lived here for less than one year.

Figure 5. Years in Dallas–Fort Worth



Tribal Identification. Most of those interviewed (about 85%) had a tribal ID or a CDIB card, or both. However, only about half (52%) said that they vote in tribal elections. About one third (34%) said they were Choctaw; other tribes were represented by 7% or less of those interviewed (Table 2).

Table 2

Tribal Affiliation

Tribe	AIRRTC study Frequency	AIRRTC study %	M&T %	DISD %	DIC/MH %
Choctaw	51	34	21	22	27
Cherokee	11	7	16	4	8
Navajo	9	6	10	10	5
Comanche	9	6	4.5	3	
Sioux	7	5	4	2	4
Kiowa	6	4	4	+	12
Creek	5	3	4	4	6
Apache	3	2	2	+	2
Arapaho	3	2	+	+	
Ponca	3	2	+		5
Seminole	2	1	+	2	
Other tribes	8	5	28		
Mixed tribal ancestry	33	22			
Number of other tribes	8		38	29	38
Total sample size	150		1,260+	512	320

Note. "+" indicates an unknown number greater than zero
Sources: M & T: McClure & Taylor, 1973
DISD: Dallas Independent School District (Larney, p.c.)
DIC/MH: Dallas Inter-tribal Center, Mental Health survey (Smith, p.c.)

Marital Status. In their marital status, 39% were married, 21% had never married, 19% were divorced, and 7% were widowed. Another 14% gave some other marital status (single, separated, official or common law).

Income. In personal income, 40% said they earned less than $5,000 per year. Another 21% said they earned $5,000 to $10,000 per year. In other words, 61% earned less than $10,000 per year. On the other hand, 26% earned $10,000 to $20,000, and 13% earned more than $20,000 per year.

ZIP Codes. As was the case with the McClure and Taylor (1973) study, the largest number of interviewees in the city of Dallas gave addresses in Oak Cliff, especially in ZIP codes 75211 and 75208. These ZIP codes lie west of the Dallas Inter-tribal Center, which is in ZIP code 75203. A second concentration of interviews in both surveys is in ZIP code 75214 (Lakewood), which lies northeast of the Dallas Inter-tribal Center.

Fort Worth has about 91 ZIP codes. The largest number of interviews in any ZIP code was only 5 (Haltom City, 76117), and respondents gave addresses in 12 different Fort Worth ZIP codes.

Disability Information

Both in the working groups and in interviews, many people were not familiar with the term "disability." Interviewers discovered that if they are asked if they have a disability, interviewees say no, I don't have that. But if they are asked about their health problems, then they start telling you. (See also Appendix H, Fort Worth Community meeting, Excerpt 4.)

Because many American Indians do not know what the federal government means by the term "disability," we asked for disability-related information in several different ways. On their contact logs, the interviewers were asked to identify the respondent's primary disability. Their responses are listed in Table 3. The most common primary disability was diabetes. This was identified as the primary disability for 38 (25%) of those interviewed. It was one of the major disabilities of 9 others and was one of several disabilities for 10 more, for a total of 57 out of 150 cases (38%). However, the most frequent disability overall was visual impairment or low vision (Table 3).

Table 3

Disabilities by Category (N=150)

Disability	Primary		Major		Other		Total	
	n	%	n	% of 150	n	% of 150	n	% of 150
Visual impairment or glaucoma	5	3.3%	5	3.3%	101	7.3%	106	70.7%
Orthopedic disorder or functional limitation	15	10.0%	25	16.7%	66	44.0%	91	60.7%
Mental/emotional problems	11	7.3%	12	8.0%	53	35.3%	56	43.3%
Diabetes	38	25.3%	47	31.3%	10	6.7%	57	38.0%
Heart problems, high blood pressure, hypertension	18	12.0%	21	14.0%	31	20.7%	52	34.7%
Alcoholism or substance abuse	26	17.3%	26	17.3%	7	4.7%	33	22.0%
Hearing impairment or deaf	6	4.0%	6	4.0%	27	18.0%	33	22.0%
Arthritis	5	3.3%	5	3.3%	26	17.3%	31	20.7%
Digestive or kidney problems	6	4.0%	9	6.0%	2	1.3%	11	7.3%
Asthma	3	2.0%	5	3.3%	2	1.3%	7	4.7%
Cancer	2	1.3%	3	2.0%	1	0.7%	4	2.7%
Skin diseases	2	1.3%	2	1.3%	3	2.0%	5	3.3%
Multiple major disabilities	13	8.7%	13	8.7%			13	8.7%

Note. Frequencies add up to more than 150 because many individuals have more than one disability.

Visual Impairments and Low Vision. Information about visual impairments was sought in several different ways (Table 4). The most common (92 of 150, 61%) was in response to DI-2.3a, "Do you use eyeglasses?" In addition to these, ten (10) more respondents indicated that they don't use glasses but need them (DI-2.3b), bringing the total number with a visual impairment or low vision to 102. In addition to these, four (4) more indicated that while they don't use or need eyeglasses, their ability to see was limited (DI-8.3). This results in a total of 106, or 71% of the respondents, who indicated some visual impairment or low vision problem. There was, of course, overlap in the answers. For example, 65 people who said they used eyeglasses indicated the need for new or improved eyeglasses (DI-2.3b). And most of those who said their disability limited their ability to see also said they used or needed glasses. In only six (6) cases was the person's ability to read (6 of 44, 14%) limited by his or her disability without also indicating one of the other items summarized in Table 4. These cases were not counted as necessarily indicating a visual impairment or low vision because the problem might be with a learning disability or some other circumstance.

Table 4

Visual Impairments

Item	Question	Response	Sample Size	Percent of 150
DI-1.4	Describe your disability	Blindness	5	3%
DI-1.31	Describe your disability	Visual impairment	52	34%
DI-2.3a	Do you use eyeglasses?	yes	92	61%
DI-2.3b	Do you need eyeglasses?	yes	75	5%
DI-2.4	Do you use or need Braille?	yes	0	0
DI-8.1	Does your disability limit you in reading?	yes	4	2%
DI-8.3	Does your disability limit you in seeing?	yes	51	34%
Total	Visual impairment or low vision (counting each person only once)		106	71%

Orthopedic Disorders and Functional Limitations. Here again, we asked for information in several different ways. First, the interviewer asked the respondent to describe his or her disability. Responses included in this category included orthopedic disorder, amputation, stroke, spinal cord disorder, polio, and multiple sclerosis. Thirty-one (31) respondents mentioned one or more of these conditions.

Second, the interviewer asked if the respondent used or needed assistive devices, such as a cane, walker, wheelchair, or prosthesis. A total of 30 respondents indicated that they used or needed one or more of these assistive devices. Five (5) of these did not presently use one of these assistive devices but needed one or more of them.

Third, the interviewer asked if the respondents' disability limited them in using their hands, walking, sitting, lifting, or in manual tasks. A total of 88 respondents indicated a limitation in one or more of these activities. Of these, 29 also used an assistive device, 28 mentioned an orthopedic or related disability, and 27 said that they had arthritis. Only 31 of the 88 who indicated a functional limitation did not also indicate an orthopedic or related disability, an assistive device, or arthritis. Some of these may have undiagnosed or untreated orthopedic disorders. The specific results are tabulated in Table 5.

Table 5

Orthopedic Impairments and Their Resulting Functional Limitations

Item	Question	Response	Sample Size	Percent of 150
Orthopedic Impairments				
DI-1.1	Describe your disability.	Amputation	5	3.0%
DI-1.18		Multiple Sclerosis	1	.6%
DI-1.21		Orthopedic disorder	17	11.0%
DI-1.23		Polio	1	.6%
DI-1.27		Spinal cord disorder	3	2.0%
DI-1.28		Stroke	5	3.0%
(One or more of the above, DI-1 subtotal: 31, or 21% of 150)				
Assistive Devices				
DI-2.1	Do you use a cane?	yes	13	8.0%
	If not, do you need one?	yes	4	2.0%
DI-2.2	Do you use a wheelchair?	yes	5	3.0%
	If not, do you need one?	yes	2	1.0%
DI-2.7	Do you use a walker?	yes	2	1.0%
	If not, do you need one?	yes	1	.6%
4DI-2.9	Do you use a prosthesis	yes	11	7.0%
	If not, do you need one?	yes	0	0
(One or more of the above, DI-2 subtotal: 30, or 20% of 150)				
Functional Limitations				
DI-8.	Does your disability limit you in:			
.7	using your arms?	yes	33	22%
.8	using your hands?	yes	32	21%
.9	walking?	yes	55	36%
.10	sitting?	yes	55	36%
.11	lifting?	yes	49	32%
.14	manual tasks?	yes	46	30%
(One or more of the above, DI-8 subtotal: 88, or 59% of 150)				
Combined total, DI-1, DI-2, and DI-8: (counting each person once)			91	61

Mental or Emotional Disorders. This set of disabilities was identified in two ways. First, the respondent was asked to describe his or her disability. The disorders mentioned in this category include, in descending order of frequency, neurological impairments; depression; eating disorders; epilepsy; personality disorders; specific learning disabilities, Bipolar disorder; mental retardation; and traumatic brain injury (Table 6). Thirty-five (35) respondents indicated one or more of these disabilities.

Later, the respondents were asked if their disability limits their memory or ability to learn (Table 6). Fifty-two (52) of them indicated one or more of these functional limitations. Twenty-two (22) of these indicated both a functional limitation and one of the mental or emotional problems just listed. These combine for a total of 65 respondents with one or more mental or emotional disorders or related functional limitations.

Table 6

Mental or Emotional Problems

Item	Question	Response	Size	Sample Percent of 150
Mental or Emotional Disorders				
DI-1.3	Describe your disability.	Bipolar disorder	3	2%
DI-1.7		Depression	10	6%
DI-1.10		Eating disorder	7	4%
DI-1.11		Epilepsy	4	2%
DI-1.17		Mental retardation	3	2%
DI-1.20		Neurological impairment	10	6%
DI-1.22		Personality disorder	4	2%
DI-1.26		Specific learning disorder	4	2%
DI-1.30		Traumatic brain injury	2	1%
(One or more of the above, DI-1 subtotal: 35, or 23% of 150)				
Functional Limitations				
DI-8	Does your disability limit you in:			
.6	remembering?	yes	51	34%
.13	learning?	yes	21	14%
(One or more of the above, DI-8 subtotal: 52, or 35% of 150)				
Combined total, DI-1 and DI-8: (counting each person only once)			65	43%

Heart Problems. Respondents with heart problems were identified either by the interviewer's identification of their primary disability or in response to item DI-1, "Please describe your disability." Hypertension or high blood pressure was mentioned more than twice as often as other heart problems.

Hearing Impairments. There were a number of questions designed to gain information about any hearing impairments (Table 7). The most common (28 of 150, 19%) was in response to DI-8.4, "Does your disability limit you in hearing?" In addition to these, 5 more respondents described themselves as having a hearing impairment (DI-1.12), raising the total to 33 cases (22% of the 150 interviews). A total of 18 respondents described their disability as a hearing impairment and also indicated that their disability limited their hearing. Of these cases, five (5) described themselves as deaf, and seven (7) considered their hearing impairment to be their primary disability. Another series of questions (DI-2) asked for information relating to assistive devices and techniques. Respondents were shown a list which included sign language, lip reading, and hearing aids, and were asked, "Do you use any of the following because of your disability?" They were also asked to indicate if they needed new or improved devices or techniques. So, for example, the respondent who used sign language was apparently satisfied with his or her sign language, so did not express a need for new or improved sign language. Although this was intended as a follow-up question, responses concerning the hearing aids indicated that some who did not have hearing aids felt that they needed them and used DI-2.8b to indicate this.

Relatives with a Disability (SO-3). We also asked the interviewees, "Do any of your relatives have disabilities or long-term illnesses?" Most of them (116, or 77%) indicated that they did.

Table 7

Hearing Impairments

Item	Question	Response	Frequency	Percent of 150
DI-1.8	Describe your disability.	Deaf	5	3%
DI-1.12	Describe your disability	Hearing impairment	23	15%
DI-2.5a	Do you use sign language?	yes	1	.6%
DI-2.5b	Do you need new/improved sign language?	yes	0	0%
DI-2.6a	Do you use lip reading?	yes	4	2%
DI.2.6b	Do you need new/improved lip reading?	yes	2	1%
DI-2.8a	Do you use a hearing aid?	yes	7	4%
DI-2.8b	Do you need a new/improved hearing aid	yes	9	6%
DI-8.4	Does your disability limit you in *hearing*?	yes	28	18%
Total	Hearing impairments (counting each person only once)		33	22%

Medication. Medications were used by 85 of the interviewees (57%). Of these, 31 (36%) said that they experienced side effects. Also, 40 (27% of 150) indicated that they either needed medication or needed new or improved medication. Fourteen (14) said that they used Indian medicine, and three (3) said they needed Indian medicine.

Service Information

Respondents were asked a series of questions about what services they had received during the past year from an agency, how helpful the services were, and why they may not have received some of the services they need or want (Items SI-1 to SI-11). The service received by the largest number of respondents (Table 8) was medical care (108 respondents, 72%). Most respondents (86, 57%) had had some help with services, most frequently with getting food or getting or applying for cash or food benefits or programs like SSI or food stamps. Most respondents had a positive experience with these services, indicating that they were "helpful" (YES/4) or "Made my problems much better" (YES/5). There was little variation in the average helpfulness of each service (Table 8). The lowest rating (3.83) was for help to get or keep a job, or training (including education) to be able to work (SI-5). The highest rating (4.22) was for help getting housing (SI-2c) and help for problems with alcohol (SI-9).

Overall, the barriers to service most commonly indicated were "The services were not offered to me" (first choice on the list of possible responses) or "Did not know of service" (sixth on the list of choices). Two services that they wanted or needed but did not receive stand out from all the rest: help to get or keep a job or training (including education) to be able to work (SI-5; 43 respondents), and dental care (SI-7; 50 respondents). The most common reason cited for not receiving help to get or keep a job, or training to be able to work, was "The services were not offered to me" (23 respondents). The most common reason offered for not receiving dental care is "I could not afford to use the service" (18 respondents). The responses to all of these questions are tabulated in Table 9. Barriers to service delivery were also discussed at the community meetings (Appendix H, Fort Worth excerpts 1 and 2; Dallas excerpt 3).

Table 8

Services Received within the Past Year

	"Have you RECEIVED the service?			"How helpful was it?" *See note for scale*					Average helpfulness
Item	Question	No	Yes	1	2	3	4	5	
SI-1.	Has anyone helped you with services or put you in touch with those who could help you?	65	86	0	4	19	39	25	3.98
SI-2.	Have you received help:								
	a. getting food?	95	55	0	4	10	22	19	4.02
	b. getting clothing?	127	22	0	2	4	7	8	4.00
	c. getting housing?	130	18	1	1	2	3	11	4.22
SI-3.	Have you received help getting or applying for cash or food benefits or programs, like SSI or food stamps?	99	52	1	2	12	18	18	3.98
SI-4.	Have you received instruction on how to:								
	a. cook?	140	11	0	0	3	5	3	4.00
	b. clean?	142	9	0	0	4	1	4	4.00
	c. shop?	146	5	0	0	2	0	3	4.20
	d. use transportation?	144	7	0	1	1	3	2	3.86
SI-5.	Have you received help to get or keep a job, or training (including education) to be able to work?	128	23	0	5	1	10	7	3.83
	Have you received:								
SI-6.	medical care?	42	108	0	4	9	42	52	4.33
SI-7.	dental care?	104	47	0	5	6	11	25	4.19
SI-8.	Have you received counseling, such as individual, group, or family counseling?	115	36	0	1	5	15	14	4.20
	Have you received help to handle any [of your] problems with:								
SI-9.	alcohol?	128	23	0	2	1	10	10	4.22
SI-10.	drugs?	134	17	0	1	2	7	7	4.18
SI-11.	Have you received help to handle any problems with the police or the law?	136	15	0	1	1	7	5	4.14
	Total		534	2	33	82	200	213	4.11

Note. Scale of helpfulness ranges from :
1 = "Made my problems much worse" to 5 = "Made my problems much better"

Table 9

Services Needed in Past Year but not Received

Services	Interviewees needing but not receiving		Barriers		
	n	%	n	%	Barrier
Dental care	50	33%	18	12%	Could not afford.
			9	6%	Not offered to me.
Vocational assistance	43	29%	23	12%	Not offered to me.
			7	6%	Didn't know about it.
Help getting housing	35	23%	18	12%	Not offered to me.
			9	6%	Didn't know about it.
Help getting clothing	33	22%	18	12%	Not offered to me.
			8	5%	Didn't know about it.
Help getting food	27	18%	11	7%	Not offered to me.
			6	4%	Didn't know about it.
Help getting benefits	22	15%	9	6%	Not offered to me.
			7	5%	Didn't know about it.
Service coordination	21	14%	15	11%	Not offered to me.
			5	3%	No transportation.
Counseling	20	13%	8	5%	Not offered to me.
Help with daily living skills	17	11%	6	4%	Didn't know about it.
			5	3%	Not offered to me.
Medical care	16	11%	7	5%	Not offered to me.
			6	4%	Could not afford.
Alcohol treatment	9	6%	4	3%	Didn't know about it.
Drug treatment	3	2%	3	2%	Didn't know about it.
Legal assistance	6	4%	2	1%	Not offered to me.

The respondents were also asked which services they are *currently* receiving. Their responses are shown in Table 10, in decreasing order of frequency.

Table 10

Current Service Information (SI-12)

Service	Yes	%Yes
Dallas Inter–tribal Center	72	48%
Other Indian service agency	19	13%
Private medical doctor	44	29%
Medicare/Medicaid	24	16%
Alcohol or substance abuse counseling program	23	15%
Social Security Administration	21	14%
Indian medicine	14	9%
Your church	14	9%
School (e.g., teacher, counselor)	9	6%
State Division of Social Services	9	6%
Psychologist	6	4%
State Division of VR	6	4%
Veterans' Affairs Administration	6	4%
Sweat lodge	6	4%
Mental health program	4	3%
State Job Service program	3	2%
Senior citizen's program	2	1%
State Division of DD	1	1%
Other	10	7%

Consumer Concerns

General Profile of all 150 Respondents. Now let us look at the consumer concerns section of the questionnaire. There were 37 items in this section, and each was rated on a scale of 0 to 100 according to its importance and the degree of consumer satisfaction. For all items, the average importance rating was 88, and the average satisfaction was 55. The standard deviation for the importance ratings was 5.7, and for the satisfaction ratings was 7.6 (Table 11). The complete list of items and their ratings is given in Appendix G.

First, let's look at some of the relative strengths of the Dallas–Fort Worth metroplex that this survey identified (Table 11). For the purposes of this report, a "relative strength" is an item that scores above average in both importance and satisfaction. The relative strengths listed in the table all have a score of at least 89 in importance, and a score of at least 58 in satisfaction. They are listed in descending order by a "Relative Strength Index," which is calculated as the harmonic mean (i.e., the square root of the product) of Importance times Satisfaction. The "relative strengths" all have an above-average Relative Strength Index. An importance rating, satisfaction rating, or relative strength index that is more than one standard deviation above the mean is marked by an asterisk (*) in the table. In this and subsequent tables, some items that are only a little above average in importance and satisfaction may not be shown.

Table 11

American Indians with Disabilities Community Concerns Assessment, Relative Strengths, Dallas–Fort Worth, Texas (N=150)

Item	Survey Question	Average importance	Average satisfaction	Relative strength index
CC-13	You can call for and get help in an emergency.	97*	71*	83*
CC-7.	You feel safe in your home and neighborhood.	96*	64*	78*
CC-25.	Accessible parking spaces (for example, handicapped parking) are available and adequate.	89	67*	77*
CC-9.	Health service providers and social agency staff treat you with dignity and respect and are sensitive to your disability.	92	64*	77*
CC-1.	You can successfully obtain services for your own needs.	90	64*	76
CC-37.	Checkout stands and aisles in stores are safe and accessible for shoppers who have disabilities.	92	61	75*
CC-16.	Doctors and hospitals accept Medicaid and Medicare when you need it.	92	60	74
CC-8.	You are treated fairly by the police and court officials.	90	60	73
CC-24.	Public transit systems (such as buses and cabs) are safe and people with disabilities can get in and out without difficulty.	90	58	72
All 37 Items, Average		88	55	69
	Standard deviation	5.7	7.6	5.5

Next, let us look at the relative problem areas identified in this section (Table 12). These are the items that were rated high in Importance but low in Satisfaction. For the purposes of this report, this means above average in importance but below average in satisfaction. This means that both STRENGTHS and PROBLEMS rank high (i.e., above average) in Importance, but the Strengths all have a Satisfaction rating of at least 58, whereas the Problems all have a Satisfaction rating of 51 or lower. They are listed in descending order of a "Relative Problem Index," which is calculated as the harmonic mean (i.e., square root of the product) of Importance times 100-Satisfaction. The "relative problems" all have an above-average Relative Problem Index and a below-average Relative Strength Index. Importance ratings and relative problem indexes that are at least one standard deviation above the mean are marked by an asterisk (*), as are Satisfaction ratings that are at least one standard deviation below the mean.

Two items not shown, CC-15 and CC-22, have slightly higher than average importance ratings and relative problem indexes, and slightly below average satisfaction ratings. Two items that are shown in Table 12, CC-32 and CC-33 were only slightly above average in importance but were sufficiently below average in satisfaction and sufficiently above average in their relative problem indexes to merit attention. These relative problems were presented at the community meetings, and there was some discussion of some of them (e.g. Appendix H, Dallas community meeting, excerpts 2 [regarding CC-35], and 6 [regarding CC-11]).

Table 12

American Indians with Disabilities Community Concerns Assessment, Relative Problems, Dallas–Fort Worth, Texas (N=150)

Item	Survey Question	Average importance	Average satisfaction	Relative problem index
CC-11	Affordable health care insurance is available to you.	93	48	70*
CC-32	Employment agencies and prospective employers focus on the strengths and abilities, rather than the problems and difficulties, of an applicant with a disability.	89	46*	69*
CC-36	You know your rights (regarding, for example, housing, employment, social services) as a citizen with a disability.	93	49	69*
CC-34	Adequate career counseling is available to all American Indians who have a disability.	91	48	69*
CC-35	Assistive devices (such as wheelchairs, braces, hearing aids, and so on) are available and affordable.	92	49	68*
CC-19	Quality treatment and prevention programs for alcohol and substance abuse are available for adolescents and other young people.	92	51	67
CC-28.	Affordable housing (both private and public) is available and accessible to residents with all types of disabilities.	90	50	67
CC-33	Special programs to help young people with disabilities make the transition from public school to employment and community living are available and adequate.	89	49	67
All 37 Items, Average		88	55	62
	Standard Deviation	5.7	7.6	5.6

Educational Information

When asked if they felt their education adequately prepared them for the world of work, 78 (52%) said yes. Eighty-six (57%) indicated that they felt that their education adequately prepared them for continuing their education beyond high school, and 109 (73%) indicated that they would like to increase their education.

Social Information

When asked if anyone lives with them, 118 (79%) said yes. The most frequent categories of persons living with the respondent were spouse and children (Table 13). Most of the respondents (129, 86%) also indicated that there is someone they can count on to give help when they need it. They seemed relatively content with their living arrangements (Table 14). The least satisfactory aspect of their living arrangement was related to safety and getting to services when they needed to.

Table 13

SO-2. People Living with Respondent

Item	Relationship	Full time n	Full time %	Part time n	Part time %
11	Your child(ren)	47	31%	4	3%
7	Spouse	46	31%	1	1%
1	Parent(s)	23	15%		
8	Grandchild(ren)	13	9%	3	2%
2	Brother(s)	10	7%		
3	Sister(s)	7	5%		
12	Other(s)	7	5%	1	1%
6	Uncle(s)	1	1%		
9	Niece(s)	1	1%		
10	Nephew(s)				
5	Aunt(s)				
4	Grandparent(s)				

Table 14

Consumer Attitudes about Living Arrangements

Subject	n	Disagree a lot (1)	Disagree (2)	Agree (3)	Agree a lot (4)	Mean Agreement
(6) The people I live with care about what happens to me.	141	1%	4%	43%	46%	3.4
(9) The people I live with make me feel comfortable.	138	1%	6%	51%	34%	3.3
(1) I like the number of people who live with me.	141	1%	9%	51%	33%	3.2
(5) It is convenient to get my clothes washed, go shopping, and so on.	148	2%	13%	60%	24%	3.1
(8) The people in the neighborhood are nice to me.	125	1%	14%	54%	14%	3.0
(7) I am happy where I live.	148	5%	22%	51%	21%	2.9
(4) If I could, I would live somewhere else.	147	3%	27%	45%	24%	2.9
(3) I feel safe from danger.	149	10%	26%	51%	12%	2.7
(2) It is difficult to get services when I need to.	141	7%	39%	40%	8%	2.5

About half (51%) of the respondents indicated that they saw their friends and relatives as often as they want to. More than half (55%) were in daily contact with their immediate families. Another 14%, however, saw their immediate families only once or twice a year or less. Contact with their extended family (families other than their parents, dependent children, or spouse) was less frequent. For almost half (46%), contact was absent or rare (once or twice a year). For another 42%, contact was more frequent (several times a month or several times a week). For the remainder (11%), contact was daily or every other day.

About half (49%) of the respondents lived in a house. Of these, most (58%) were home owners; the others were renters. More than a third (37%) lived in an apartment. Others (11, 7%) lived in a treatment center or half-way house.

It should be noted that a number of interviewees were on the verge of homelessness. At the community meeting in Dallas, the Gaston Avenue area was mentioned as a place where "a lot" of homeless people are found (Appendix H, Dallas community meeting, excerpt 7). This street is in ZIP code 75214, west of White Rock Lake. Thirteen interviewees gave an address on this street, and three others gave an address on some other street in the same ZIP code area.

Employment Information

At the time of the interviews, 67 (45%) of the respondents were working for pay. Forty-eight (72%) of these were working full-time, and 16 (24%) were working part-time. Forty-eight (48) were satisfied with their jobs. Forty-two (42) of the 150 respondents were looking for a job. Of those who were not working for pay, 50% (42) said they were unemployed because of disability, 13% (11) said they were retired on disability, 11% (9) said they were retired, 6% (5) said they were full-time students, 2% (2) were seasonal workers, and the rest had some other explanation.

A series of questions was asked about their work experience (paid or unpaid) and whether they had ever had any problems finding or keeping a job because of certain circumstances, listed in Table 15 in descending order of importance. The problem most often cited for finding or keeping a job was their disability (49 respondents, 33%), followed by a lack of jobs where they live (41 respondents, 27%), and a lack of transportation (34 cases, 23%).

Table 15

Responses to: "Considering your work experience (paid or unpaid) have you ever had any problems finding or keeping a job because (of):"

Item	Reason	Yes n	 % of 150
EM-5a.	... your disability?	49	33%
EM-5c.	... there are no jobs available where you live?	41	27%
EM-5k.	... you do not have transportation?	34	23%
EM-5m.	... you don't have enough money to look for work?	33	22%
EM-5b.	... you don't have the right job skills that are needed?	32	21%
EM-5f.	... employers do not give you a fair chance?	28	19%
EM-5h.	... your ethnic background?	24	16%
EM-5l.	... your home responsibilities?	20	13%
EM-5e.	... you don't know how to best fill out application forms?	19	13%
EM-5d.	... you don't know the best ways to look for jobs?	16	11%
EM-5j.	... your age?	10	7%
EM-5i.	... your sex?	5	3%
EM-5g.	... your English is not good enough to get a job?	5	3%

Profile: By County

In this and subsequent sections, the profile of subsets of respondents linked by a common characteristic will be examined. In general, the responses are similar; therefore, only noteworthy differences with the general profile of all 150 respondents will be described.

Dallas County. Most of the interviews (n = 114) were in Dallas county. In fact, most (n = 86) were done in the city of Dallas. However, 15 were done in Grand Prairie, six (6) were done in Irving, and several were done in Garland, Mesquite, Farmer's Branch, and Duncanville (Table 1). Because so many of the interviews were done in Dallas County, responses for this county were essentially the same as for the general profile (Table 11).

As the result of minor changes in the numbers for the consumer concerns, several new items are added to the Relative Strengths (Table 16) and the Relative Problems (Table 17).

Table 16

Dallas County, Relative Strengths (n=114)

Item	Survey Question	Average Importance	Average Satisfaction	Relative Strength Index
CC-13	You can call for and get help in an emergency. †	98* (+1)	71*	83*
CC-7.	You feel safe in your home and neighborhood.†	96*	66* (+2)	80* (+2)
CC-25.	Accessible parking spaces (for example handicapped parking) are available and adequate.†	92 (+3)	68* (+1)	79* (+2)
CC-1.	You can successfully obtain services for your own needs.†	89 (-1)	69* (+5)	78* (+2)
CC-9.	Health service providers and social agency staff treat with dignity and respect and are sensitive to your disability.†	93 (+1)	64	77*
CC-37.	Checkout stands and aisles in stores are safe and accessible for shoppers who have disabilities.†	94* (+2)	61	76* (+1)
CC-8.	You are treated fairly by the police and court officials.†	90	64 (+4)	76* (+3)
CC-16.	Doctors and hospitals accept Medicaid and Medicare when you need it.†	94* (+2)	59 (-1)	74
CC-24.	Public transit systems (such as buses and cabs) are safe, and people with disabilities can get in and out without difficulty.†	94* (+4)	59 (+1)	74 (+2)
CC-18.	You can trust service providers to suggest the right services for you and your family.	89 (+1)	60 (+1)	73 (+1)
CC-2.	The Indian community understands the needs of its members with disabilities.	90 (-1)	59 (+4)	73 (+2)
All 37 Items, Average		88	56 (+1)	70 (+1)
	Standard Deviation	5.9	8.5	6.0

Note. "*" indicates more than one standard deviation above or below the average for all 37 items.
Note. Numbers in parenthesis show gain or loss of rating points when compared with ratings by all 150 respondents.
† Also considered a relative strength by all 150 respondents (Table 11).

Table 17

Dallas County, Relative Problems (n=114)

Item	Survey Question	Average Importance	Average Satisfaction	Relative Problem Index
CC-3.	Local media provides education and adequate information for American Indians who have disabilities.	90 (+2)	41* (+2)	73*
CC-11.	Affordable health care insurance.°	93	48	70*
CC-32.	Employment agencies and prospective employers focus on the strengths and abilities, rather than the problems and difficulties, of an applicant with a disability.°	90 (+1)	46*	70* (+1)
CC-36.	You know your rights (regarding, for example, housing, employment, social services) as a citizen with a disability.°	94* (+1)	48 (-1)	70* (+1)
CC-35.	Assistive devices (such as wheelchairs, braces, hearing aids, and so on) are available and affordable.°	92	47* (-2)	70* (+2)
CC-34.	Adequate career counseling is available to all American Indians who have a disability.°	92 (+1)	48	69*
CC-33.	Special programs to help young people with disabilities make the transition from public school to employment and community living are available and adequate.°	90 (+1)	48 (-1)	68 (+1)
CC-28.	Affordable housing (both private and public) is available and accessible to residents with all types of disabilities.°	92 (+2)	51 (+1)	67
CC-15.	Doctors, nurses, and other health service providers have enough knowledge of your culture to provide safe and competent health care to American Indians with disabilities.	91	51 (-1)	67 (+1)
CC-17.	Social agencies have outreach services to contact all American Indians in the community who have a disability.	89 (+1)	49	67
CC-19.	Quality treatment and prevention programs for alcohol and substance abuse are available for adolescents and other young people.°	92	52 (+1)	66 (-1)
CC-22.	Financial assistance is available to students with disabilities who want to attend college or technical school.	90	54 (+1)	64 (-1)
All 37 Items, Average		88	56 (+1)	62
	Standard Deviation	5.9	8.5	6.4

Note. "*" indicates more than one standard deviation above or below the average for all 37 items.
Note. Numbers in parenthesis show gain or loss of rating points when compared with ratings by all 150 respondents.
° Also considered a relative problem by all 150 respondents (Table 12).

Tarrant County. There were a total of 26 interviews conducted in Tarrant County: 19 in the city of Fort Worth, five (5) in Haltom City, and one (1) in Arlington. As in Dallas County, the most frequent tribal affiliation was Choctaw (n = 9, 35%). Cherokee, Kiowa, and Creek were next in frequency (n = 3 each, 12% each). Other tribal affiliations were less frequent or of mixed ancestry. As in Dallas County, the most frequent disability category was visual impairment (including glaucoma) (n = 17, 65%). Heart problems were next (n = 11, 42%), followed by orthopedic disorders, and mental/emotional problems (n = 9 each, 35%), hearing or deafness, and arthritis (n = 8 each, 31%).

The biggest difference with the consumer concerns ratings compared with Dallas County is that the biggest problem identified by the respondents in Tarrant County was dissatisfaction with statement CC-2, "The Indian community understands the needs of its members with disabilities" (Table 19). This relative problem in Tarrant County was actually viewed as a strength in Dallas County (Table 16). Another shift from "strength" to "problem" is item CC-1 (Table 19). On the other hand, a Dallas County relative problem (CC-15, Table 17) is regarded in Tarrant County as a relative strength (Table 18) because of an increase in the satisfaction rating. The other changes are shown in Tables 15 and 16.

Table 18

Tarrant County, Relative Strengths (n=26)

Item	Survey Question	Average Importance		Average Satisfaction		Relative Strength Index	
CC-13.	You can call for and get help in an emergency.†	94*	(-3)	71*		82*	(-1)
CC-9.	Health service providers and social agency staff treat with dignity and respect and are sensitive to your disability.†	91	(-1)	65*	(+1)	77*	
CC-7.	You feel safe in your home and neighborhood.†	95*	(-1)	57	(-7)	74*	(-1)
CC-5.	American Indian cultural and social events, educational programs, and religious services are barrier-free and accessible (including restrooms).	87	(+1)	59	(-6)	72	(-3)
CC-14.	AIDS education and prevention services are available to American Indians.	92	(+3)	55		71	(+1)
CC-15.	Doctors, nurses, and other health service providers have enough knowledge of your culture to provide safe and competent health care to American Indians with disabilities.	91		55	(+3)	71	(+2)
All 37 Items, average		86	(-2)	54	(-1)	68	(-1)
	Standard deviation	6.7		6.3		4.7	

Note. "*" indicates more than one standard deviation above or below the average for all 37 items.

Note. Numbers in parenthesis show gain or loss of rating points when compared with ratings by all 150 respondents.

† Also considered a relative strength by all 150 respondents (Table 11).

Table 19

Tarrant County, Relative Problems (n=26)

Item	Survey Question	Average Importance	Average Satisfaction	Relative Problem Index
CC-2.	The Indian community understands the needs of its members with disabilities.	93* (+2)	42*(-13)	73* (+9)
CC-11.	Affordable health care insurance is available to you.°	94* (+1)	49 (+1)	69* (-1)
CC-34.	Adequate career counseling is available to all American Indians who have a disability.°	92 (+1)	49 (+1)	69* (-1)
CC-1.	You can successfully obtain services for your own needs.†	93* (+3)	51 (-13)	68*(+11)
CC-35.	Assistive devices (such as wheelchairs, braces, hearing aids, and so on) are available and affordable.°	92	53 (+4)	66 (-1)
CC-19.	Quality treatment and prevention programs for alcohol and substance abuse are available for adolescents and other young people.°	91 (-1)	52 (+1)	66 (-1)
CC-17.	Social agencies have outreach services to contact all American Indians in the community who have a disability.	87 (-1)	50 (+1)	66 (-1)
CC-33.	Special programs to help young people with disabilities make the transition from public school to employment and community living are available and adequate.°	87 (-2)	53 (+4)	64 (-3)
CC-22.	Financial assistance is available to students with disabilities who want to attend college or technical school.	90	51 (-2)	66 (+1)
All 37 Items, average		86 (-2)	54 (-1)	62
	Standard deviation	6.7	6.3	5.2
Dropped from Relative Problems:				
CC-32.	Employment agencies and prospective employers focus on the strengths and abilities, rather than the problems and difficulties, of an applicant with a disability.°	86 (-3)	48 (+2)	67 (-2)
CC-36.	You know your rights (regarding, for example, housing, employment, social services) as a citizen with a disability.°	90 (-3)	54 (+5)	64 (-5)
CC-28.	Affordable housing (both private and public) is available and accessible to residents with all types of disabilities.°	84 (-6)	50	65 (-2)

Note. "*" indicates more than one standard deviation above or below the average for all 37 items.
Note. Numbers in parenthesis show gain or loss of rating points when compared with ratings by all 150 respondents.
† Also considered a relative strength by all 150 respondents (Table 11).
° Also considered a relative problem by all 150 respondents (Table 12).

Profile: By Sex

The Relative Strengths and Relative Problems identified by men and women were compared. All differences were minor and were essentially the same as for the metroplex as a whole.

Profile: By Age

Ages 7 to 21. There were 12 respondents age 21 or under; their ages were 7, 14, 14, 15, 15, 16, 16, 17, 19, 19, 20, and 21. A parent was interviewed on behalf of the 7–year–old. The responses of this group to the consumer concerns items differed markedly from the other respondents. The average importance of all 37 items in the concerns section for this age group was 78 (Table 20), which is 10 less than, and more than one standard deviation less than, the average for the sample as a whole (Table 11). On the other hand, the average satisfaction for all 37 items for this age group was 63, which is 8 more than, and one standard deviation more than, the average satisfaction for all 150 respondents (Table 11).

Three of the top four relative strengths for this group are different (Table 20), and three of the relative strengths for all 150 respondents, CC-1, CC-13, and CC-24 (Table 11) are not considered strengths by this group.

Table 20

Ages 7-21, Relative Strengths (n=12)

Item	Survey Question	Average Importance	Average Satisfaction	Relative Strength Index
CC-7.	You feel safe in your home and neighborhood.†	94* (-2)	75* (+11)	84* (+6)
CC-26.	Affordable transportation services are available as needed.	92* (+5)	71 (+4)	81*(+5)
CC-5.	American Indian cultural and social events, educational programs, and religious services are barrier-free and accessible (including restrooms).	88 (+2)	73* (+8)	80* (+5)
CC-15.	Doctors, nurses, and other health service providers have enough knowledge of your culture to provide safe and competent health care to American Indians with disabilities.	94* (+3)	68(+16)	80*(+11)
CC-8.	You are treated fairly by the police and court officials.†	79 (-11)	79*(+19)	79* (+6)
CC-14.	AIDS education and prevention services are available to American Indians.	83 (-6)	75*(+20)	79* (+9)
CC-22.	Financial assistance is available to students with disabilities who want to attend college or technical school.	86 (-4)	70(+17)	78* (+9)
CC-25.	Accessible parking spaces (for example handicapped parking) are available and adequate.†	84 (-5)	70 (+3)	77
CC-9.	Health service providers and social agency staff treat with dignity and respect and are sensitive to your disability.	82 (-10)	72 (+8)	77
CC-37.	Checkout stands and aisles in stores are safe and accessible for shoppers who have disabilities.†	84 (-8)	70 (+9)	77 (+2)
CC-16.	Doctors and hospitals accept Medicaid and Medicare when you need it.†	81 (-11)	72(+12)	76 (+2)
All 37 Items, Average		78 (-10)	63 (+8)	70 (+1)
Standard deviation		10.8	9.8	7.5

Note. "*" indicates more than one standard deviation above or below the average for all 37 items.
Note. Numbers in parenthesis show gain or loss of rating points when compared with ratings by all 150 respondents.
† Also considered a relative strength by all 150 respondents (Table 11).

The most important relative problems also differ markedly (Table 21). Two of the top six relative problems (CC-24 and CC-1), including the one with the highest relative problem index (CC-24), were considered relative strengths by the respondents as a whole. Only two of the relative problems identified by this group are among the relative problems identified by all 150 respondents.

One of the special relative problems identified by this group, CC-3, is of interest because although it has the highest relative problem index and often the lowest satisfaction rating among the older age groups, does not appear in the tables for those groups because it has an average or lower than average importance rating for those groups.

Table 21

Ages 7-21, Relative Problems (n=12)

Item	Survey Question	Average Importance	Average Satisfaction	Relative Problem Index
CC-24	Public transit systems (such as buses and cabs) are safe and people with disabilities can get in and out without difficulty.†	94* (+4)	51* (-7)	68* (+7)
CC-3.	Local media provides education and adequate information for American Indians who have disabilities.	90* (+2)	53*(-14)	65* (-8)
CC-35.	Assistive devices (such as wheelchairs, braces, hearing aids, and so on) are available and affordable.°	84 (-8)	52* (+3)	63* (-3)
CC-6.	Streets and sidewalks in areas of public housing are safe and accessible.	84	53* (+2)	63* (-1)
CC-34.	Adequate career counseling is available to all American Indians who have a disability.°	80 (-11)	52* (+4)	62* (-7)
CC-1.	You can successfully obtain services for your own needs.†	80 (-10)	53*(-11)	61* (+4)
All 37 Items, Average		78 (-10)	63 (+8)	53 (-9)
	Standard deviation	10.8	9.8	8.0

Note. "*" indicates more than one standard deviation above or below the average for all 37 items.

Note. Numbers in parenthesis show gain or loss of rating points when compared with ratings by all 150 respondents.

† Also considered a relative strength by all 150 respondents (Table 11).

° Also considered a relative problem by all 150 respondents (Table 12).

Ages 23 to 39. This group of 57 respondents rated their concerns about the same way as the 150 respondents as a whole. Their top six relative strengths are the same, except that CC-25 (Table 11) was considered less than average in importance. Its place on the list of relative strengths was taken by CC-14 (Table 18). Their top eight relative problems are also the same, except for CC-35 (Table 12), which was considered less than average in importance. This relative problem was replaced by CC-27 ("Help [like advocates or legal assistance] is available for solving problems with landlords, employers, utility companies, and others").

Ages 40 to 54. This group of 50 respondents is similar in their responses to the 150 respondents as a whole. The relative strengths (Table 11) are the same, except for minor changes in the numbers. The relative problems (Table 12) are the same, except that CC-32 in Table 12 is replaced by CC-17 ("Social agencies have outreach services to contact all American Indians in the community who have a disability"), which is within one standard deviation of the mean for all ratings and indexes.

Age 55 or older. This group of 30 respondents ranges up to 81 years of age. The average satisfaction for all 37 items for this group is 63, which is 8 higher than for all 150 respondents. The pattern of their responses differs little from the norm (Table 11 and 12). The greatest relative strengths are the same, except for minor differences in the numbers. There are a few differences in the relative problems (Table 22). These involve four relative problems identified by this group that are different from those identified by the 150 respondents as a whole. Also, two of the relative problems identified by all respondents (Table 12, CC-11, CC-34) were considered by this group to be low ranking *strengths* rather than problems, because of much higher (and slightly higher than average) satisfaction ratings (Table 19, bottom).

Table 22

Ages 55-81, Relative Problems (n=30)

Item	Survey Question	Average Importance		Average Satisfaction		Relative Problem Index	
CC-28	Affordable housing (both private and public) is available and accessible to residents with all types of disabilities.°	86	(-4)	54*	(+4)	63*	(-4)
CC-22.	Financial assistance is available to students with disabilities who want to attend college or technical school.	86	(-4)	56*	(+3)	62*	(-3)
CC-19.	Quality treatment and prevention programs for alcohol and substance abuse are available for adolescents and other young people.°	92*		60	(+9)	61*	(-6)
CC-35.	Assistive devices (such as wheelchairs, braces hearing aids, and so on) are available and affordable.°	94*	(+2)	60	(+11)	61*	(-7)
CC-17.	Social agencies have outreach services to contact all American Indians in the community who have a disability.	86	(-2)	57	(+8)	61*	(-6)
CC-2.	The Indian community understands the needs of its members with disabilities.	90	(-1)	60	(+5)	60	(-4)
CC-23.	Opportunities for adults to learn reading and writing and adequate vocational training or retraining are available.	89	(-3)	61	(+6)	59	(-5)
All 37 Items, Average		85	(-3)	63	(+8)	55	(-7)
	Standard deviation	6.5		7.0		5.7	
Dropped from Relative Problems							
CC-34.	Adequate career counseling is available to all American Indians who have a disability.°	91		65	(+17)	56	(-13)
CC-11.	Affordable health care insurance is available to you.°	90	(-3)	64	(+16)	57	(-13)

Note. "*" indicates more than one standard deviation above or below the average for all 37 items.
Note. Numbers in parenthesis show gain or loss of rating points when compared with ratings by all 150 respondents.
° Also considered a relative problem by all 150 respondents (Table 12).

Profile: By Agency

Dallas Inter-tribal Center. Most of the respondents (n=83) had had some contact with the Dallas Intertribal Center. Consequently, their responses were very similar to those of all respondents. The relative strengths were essentially the same as those in Table 11, with minor changes in the numbers. The biggest change is in CC-1, for which the satisfaction rating was 8 points higher (72) for this group, resulting in a relative strength index that is 4 points higher (80).

The relative problems are also the same as those in Table 12, with a few additions. Due to an increase of 2 points in its importance rating (from 88 to 90), CC-3 appears on the list because it is above average in both importance and satisfaction for this group. It also has the highest relative problem index for this group (74, up from 73) because of its much lower than average satisfaction rating (39). Three other items could also be added (CC-14, CC-22, and CC-23), but the relative problem index for these items is lower (65-66) than the other relative problems (67-74). These same items are considered *strengths* by the respondents associated with the American Indian Center (see below).

American Indian Center. There were 24 respondents who had some connection with the American Indian Center in Grand Prairie. Their concerns differed somewhat from the others. Five of the relative strengths were the same, but four are different (Table 20). The most notable change is the addition of item CC-20. Also notable is the addition of three items (CC-14, CC-22), and CC-23), which are considered low-ranking relative *problems* (relative problem index 65-66) by the respondents who had contact with the Dallas Intertribal Center.

The respondents who have had contact with the American Indian Center also assess the relative problems somewhat differently than do the rest of the respondents. Four items are the same as in Table 12, and four are different (Table 24). It may be noteworthy that all 24 respondents in this group gave item CC-19 the highest importance rating: 100 (Table 24).

Table 23

Respondents Associated with the American Indian Center, Relative Strengths (n=24)

Item	Survey Question	Average Importance	Average Satisfaction	Relative Strength Index
CC-20	Alcohol and substance abuse counselors understand your problems and know how to help you.	98* (+16)	69* (+9)	82* (+12)
CC-7.	You feel safe in your home and neighborhood.†	96	66* (+2)	80* (+2)
CC-9.	Health service providers and social agency staff treat with dignity and respect and are sensitive to your disability.†	94 (+2)	68* (+4)	80* (+3)
CC-1.	You can successfully obtain services for your own needs.†	93 (+3)	66* (+2)	78* (+2)
CC-13.	You can call for and get help in an emergency.†	96 (-1)	59 (-12)	75 (+1)
CC-16.	Doctors and hospitals accept Medicaid and Medicare when you need it.†	97* (+5)	58 (-2)	75 (+1)
CC-14.	AIDS education and prevention services are available to American Indians.	93 (+4)	61* (+6)	75 (+5)
CC-22.	Financial assistance is available to students with disabilities who want to attend college or technical school.	95 (+5)	57 (+4)	74 (+5)
CC-23.	Opportunities for adults to learn reading and writing and adequate vocational training or retraining are available.	94 (+2)	59 (+4)	74 (+3)
All 37 Items, Average		91 (+3)	53 (-2)	69
	Standard deviation	5.9	8.2	6.1
Dropped from Relative Strengths				
CC-8.	You are treated fairly by the police and court officials.†	87 (-3)	42 (-18)	60 (-13)
CC-25.	Accessible parking spaces (for example handicapped parking) are available and adequate.†	83 (-6)	55 (-12)	68 (-9)
CC-37.	Checkout stands and aisles in stores are safe and accessible for shoppers who have disabilities.†	87 (-5)	54 (-7)	69 (-6)

Note. "*" indicates more than one standard deviation above or below the average for all 37 items.
Note. Numbers in parenthesis show gain or loss of rating points when compared with ratings by all 150 respondents.
† Also considered a relative strength by all 150 respondents (Table 11).

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Table 24

Respondents Associated with the American Indian Center, Relative Problems (n=24)

Item	Survey Question	Average Importance	Average Satisfaction	Relative Strength Index
CC-3.	Local media provides education and adequate information for American Indians who have disabilities.	92 (+4)	34* (-5)	78* (+5)
CC-11.	Affordable health care insurance is available to you.°	96 (+3)	41* (-7)	75* (+5)
CC-19.	Quality treatment and prevention programs for alcohol and substance abuse are available for adolescents and other young people.°	100* (+8)	45 (-6)	74* (+7)
CC-17.	Social agencies have outreach services to contact all American Indians in the community who have a disability.	94 (+6)	45 (-4)	72* (+5)
CC-27.	Help (like advocates or legal assistance) is available for solving problems with landlords, employers, utility companies, and others.	95 (+8)	47 (-1)	71* (+4)
CC-36.	You know your rights (regarding, for example, housing, employment, social services) as a citizen with a disability.°	95 (+2)	48 (-1)	70 (+1)
CC-18.	You can trust service providers to suggest the right services for you and your family.	94 (+6)	50 (-9)	69 (+9)
CC-35.	Assistive devices (such as wheelchairs, braces, hearing aids, and so on) are available and affordable.°	93 (+1)	52 (+3)	67 (-1)
All 37 Items, Average		91 (+3)	53 (-2)	65 (+3)
	Standard deviation	5.9	8.2	5.9
Dropped from Relative Problems				
CC-28.	Affordable housing (both private and public) is available and accessible to residents with all types of disabilities.°	88 (-2)	42* (-8)	71* (+4)
CC-32.	Employment agencies and prospective employers focus on the strengths and abilities, rather than the problems and difficulties, of an applicant with a disability.°	91 (+2)	45 (-1)	71* (+2)
CC-33.	Special programs to help young people with disabilities make the transition from public school to employment and community living are available and adequate.°	91 (+2)	52 (+3)	66 (-1)
CC-34.	Adequate career counseling is available to all American Indians who have a disability.°	97* (+6)	53 (=5)	68 (-1)

Note. "*" indicates more than one standard deviation above or below the average for all 37 items.
Note. Numbers in parenthesis show gain or loss of rating points when compared with ratings by all 150 respondents.
° Also considered a relative problem by all 150 respondents (Table 12).

Social Security Administration. There were 21 respondents who had had contact with the Social Security Administration. They ranged in age from 27 to 81, with an average age of 55. This compares to an average age of 42 for all 150 respondents. In this group of 21 respondents, five were less than 40 years old, and 10 were more than 60.

Their top seven relative strengths were the same as for all respondents. The respondents in this group were unanimous in giving the highest importance to CC-16 ("Doctors and hospitals accept Medicaid and Medicare when you need it."). They considered this a relative strength, as did all respondents (Table 11). They differ somewhat in their assessment of the relative problems (Table 25). Four of the relative problems are the same as for all respondents (Table 12), and two of the top three relative problems are different.

Table 25

Respondents Associated with Social Security Administration, Relative Problems (n=21)

Item	Survey Question	Average Importance	Average Satisfaction	Relative Strength Index
CC-11.	Affordable health care insurance is available to you.°	92 (-1)	39* (-9)	75* (+5)
CC-17.	Social agencies have outreach services to contact all American Indians in the community who have a disability.	92 (+4)	44* (-5)	72* (+5)
CC-2.	The Indian community understands the needs of its members with disabilities.	90 (-1)	47 (-8)	69* (+5)
CC-36.	You know your rights (regarding, for example, housing, employment, social services) as a citizen with a disability.°	91 (-2)	50 (+1)	67 (-2)
CC-32.	Employment agencies and prospective employers focus on the strengths and abilities, rather than the problems and difficulties, of an applicant with a disability.°	88 (-1)	51 (+5)	66 (-3)
CC-34.	Adequate career counseling is available to all American Indians who have a disability.°	90 (-1)	52 (+4)	66 (-3)
All 37 Items, Average		86 (-2)	55	62
	Standard deviation	7.3	9.0	6.5
Dropped from Relative Problems				
CC-19.	Quality treatment and prevention programs for alcohol and substance abuse are available for adolescents and other young people.°	96* (+4)	55 (+4)	66 (-1)
CC-28.	Affordable housing (both private and public) is available and accessible to residents with all types of disabilities.°	86 (-4)	41* (-9)	71* (+4)
CC-33.	Special programs to help young people with disabilities make the transition from public school to employment and community living are available and adequate.°	92 (+3)	56 (+7)	64 (-3)
CC-35.	Assistive devices (such as wheelchairs, braces, hearing aids, and so on) are available and affordable.°	95* (+3)	55 (+6)	65 (-3)

Note. "*" indicates more than one standard deviation above or below the average for all 37 items.
Note. Numbers in parenthesis show gain or loss of rating points when compared with ratings by all 150 respondents.
° Also considered a relative problem by all 150 respondents (Table 12).

Texas Rehabilitation Commission. Only seven respondents indicated that they had had contact with the Texas Rehabilitation Commission. Their assessment of the importance of all 37 consumer concerns was more highly variable than that of most other groups, and the average importance and average satisfaction for these items was somewhat lower (by 4 to 5 points) than the average for all 150 respondents (Table 26).

Their assessment of the relative strengths (Table 26) differed from that of the other respondents in that although four of the greatest relative strengths (relative strength index 76 to 84) were the same, the others were different. One of the others, item CC-36, was considered as a relative problem by all 150 respondents; but for this group of seven, it was considered a relative strength. This item and CC-9 were both given the highest importance rating by all seven respondents in this group.

This group also differed in four of its six most highly rated relative problems (Table 27). One of these (CC-16) was considered a *strength* by all respondents, and three of them were considered in the highest category of importance by all seven respondents.

Table 26

Respondents who have had contact with the Texas Rehabilitation Commission, Relative Strengths (n=7)

Item	Survey Question	Average Importance	Average Satisfaction	Relative Strength Index
CC-9.	Health service providers and social agency staff treat with dignity and respect and are sensitive to your disability.†	100 (+8)	71* (+7)	84* (+7)
CC-7.	You feel safe in your home and neighborhood.†	96	71* (+7)	83* (+5)
CC-1.	You can successfully obtain services for your own needs.†	89 (-1)	67* (+3)	77* (+1)
CC-13.	You can call for and get help in an emergency.†	96 (-1)	60 (-11)	76* (-7)
CC-36.	You know your rights (regarding, for example, housing, employment, social services) as a citizen with a disability.°	100 (+7)	57 (+8)	75* (+7)
CC-26.	Affordable transportation services are available as needed.	89 (+2)	64* (-3)	75* (-1)
CC-5.	American Indian cultural and social events, educational programs, and religious services are barrier-free and accessible (including restrooms).	85 (-1)	64* (-1)	74* (-1)
CC-22.	Financial assistance is available to students with disabilities who want to attend college or technical school.	92 (+2)	57 (+4)	72 (+3)
CC-18.	You can trust service providers to suggest the right services for you and your family.	96 (+8)	53 (-6)	71 (-1)
All 37 Items, Average		83 (-5)	51 (-4)	65 (-4)
	Standard deviation	13.9	9.4	8.9
Dropped from Relative Strengths				
CC-8.	You are treated fairly by the police and court officials.†	83 (-7)	41*(-19)	58 (-15)
CC-25.	Accessible parking spaces (for example handicapped parking) are available and adequate.†	78 (-11)	62* (-5)	70 (-7)
CC-37.	Checkout stands and aisles in stores are safe and accessible for shoppers who have disabilities.†	71 (-21)	50 (-11)	60 (-15)
CC-16.	Doctors and hospitals accept Medicaid and Medicare when you need it.†	100 (+8)	46 (-14)	68 (-6)

Note. "*" indicates more than one standard deviation above or below the average for all 37 items.
Note. Numbers in parenthesis show gain or loss of rating points when compared with ratings by all 150 respondents.
† Also considered a relative strength by all 150 respondents (Table 11).
° Also considered a relative problem by all 150 respondents (Table 12).

Table 27

Respondents who have had contact with the Texas Rehabilitation Commission, Relative Problems (n=7)

Item	Survey Question	Average Importance	Average Satisfaction	Relative Problem Index
CC-11.	Affordable health care insurance is available to you.°	96 (+3)	32*(-16)	81* (+11)
CC-19.	Quality treatment and prevention programs for alcohol and substance abuse are available for adolescents and other young people.°	96*(+4)	42 (-9)	75* (+8)
CC-15.	Doctors, nurses, and other health service providers have enough knowledge of your culture to provide safe and competent health care to American Indians with disabilities.	92 (+1)	39*(-13)	75* (+9)
CC-2.	The Indian community understands the needs of its members with disabilities.	92 (+1)	39*(-13)	75* (+9)
CC-23.	Opportunities for adults to learn reading and writing and adequate vocational training or retraining are available.	100 (+8)	46 (-9)	73* (+9)
CC-16.	Doctors and hospitals accept Medicaid and Medicare when you need it.†	100 (+8)	46 (-14)	73* (+12)
CC-33.	Special programs to help young people with disabilities make the transition from public school to employment and community living are available and adequate.°	89	42 (-7)	72* (+5)
CC-32.	Employment agencies and prospective employers focus on the strengths and abilities, rather than the problems and difficulties, of an applicant with a disability.°	92 (+3)	46	70 (+1)
CC-34.	Adequate career counseling is available to all American Indians who have a disability.°	92 (+1)	50 (+2)	68 (-1)
CC-35.	Assistive devices (such as wheelchairs, braces, hearing aids, and so on) are available and affordable.°	92	50 (+1)	68
All 37 Items, Average		83 (-5)	51 (-4)	63 (+1)
	Standard deviation	13.9	9.4	7.8

Note. "*" indicates more than one standard deviation above or below the average for all 37 items.
Note. Numbers in parenthesis show gain or loss of rating points when compared with ratings by all 150 respondents.
† Also considered a relative strength by all 150 respondents (Table 11).
° Also considered a relative problem by all 150 respondents (Table 12).

Profile: By Disability. The consumer concerns were also separated by six of the most common disability groups: persons with (a) diabetes, (b) a visual impairment, (c) arthritis, (d) alcohol or substance abuse, (e) a hearing impairment, or (f) heart trouble. For the most part, the *relative strengths* from the perspective of these disability groups were the same as for all respondents. The most common item added to the relative strengths by these groups was CC-26. "Affordable transportation services are available as needed." This was considered a relative strength by four of the disability groups: persons with (a) diabetes, (b) a visual impairment, (c) arthritis, and (d) heart trouble. For each of these groups, this item ranked among the seven greatest relative strengths. The group of persons with a hearing impairment (narrowly defined here by item DI.1(12), "Hearing Impairment" and DI.1(8), "Deaf"), was the only one of the six disability groups to consider item CC-2. ("The Indian community understands the needs of its members with disabilities") as a relative strength. Of the six disability groups, the one that different most from the others was the group of persons with an alcohol or substance abuse problem (DI.1(29)). The relative strengths identified by this group are shown in Table 28. The most striking addition to this list, compared to Table 11, is item CC-20, added as a result of a large increase in perceived importance. The item most often missing from the overall list of relative strengths (Table 11) was CC-8, "You are treated fairly by the police and court officials." This item was not included as a relative strength in the assessment of persons with a visual impairment, a hearing impairment, heart trouble, or alchohol and substance abuse problems.

Table 28

Respondents who have an alcohol or substance abuse problem, Relative Strengths (n=31)

Item	Survey Question	Average Importance	Average Satisfaction	Relative Strength Index
CC-20	Alcohol and substance abuse counselors understand your problems and know how to help you.	99*(+17)	56 (-4)	81*(+11)
CC-7.	You feel safe in your home and neighborhood,†	97* (+1)	64*	79* (+1)
CC-13.	You can call for and get help in an emergency.†	97*	62* (-9)	78* (-5)
CC-9.	Health service providers and social agency staff treat with dignity and respect and are sensitive to your disability.†	95 (+3)	64*	78* (+1)
CC-1.	You can successfully obtain services for your own needs.†	95 (+5)	62* (-2)	77* (+1)
CC-23.	Opportunities for adults to learn reading and writing and adequate vocational training or retraining are available.	95 (+3)	60* (+5)	75* (+4)
CC-14.	AIDS education and prevention services are available to American Indians.	94 (+5)	58 (+3)	74 (+4)
CC-16.	Doctors and hospitals accept Medicaid and Medicare when you need it.†	96 (+4)	56 (-4)	73 (-1)
CC-22.	Financial assistance is available to students with disabilities who want to attend college or technical school.	95 (+5)	55 (+2)	72 (+3)
All 37 Items, Average		91 (+3)	52 (-3)	69
	Standard deviation	5.5	7.5	5.6
Dropped from Relative Strengths				
CC-8.	You are treated fairly by the police and court officials.†	89 (-1)	43*(-17)	62 (-11)
CC-24.	Public transit systems (such as buses and cabs) are safe and people with disabilities can get in and out without difficulty.†	87 (-3)	50 (-8)	66 (-6)
CC-25.	Accessible parking spaces (for example handicapped parking) are available and adequate.†	86 (-3)	59 (-8)	71 (-6)
CC-37.	Checkout stands and aisles in stores are safe and accessible for shoppers who have disabilities.†	89 (-3)	57 (-4)	71 (-4)

Note. "*" indicates more than one standard deviation above or below the average for all 37 items.
Note. Numbers in parenthesis show gain or loss of rating points when compared with ratings by all 150 respondents.
† Also considered a relative strength by all 150 respondents (Table 11).

The assessment of relative problems by these groups was more variable than their assessment of strengths. Items CC-11, CC-19, CC-34, and CC-36 (Table 12) were identified as relative problems by all six disability groups. Item CC-35 (Table 12) was identified as a relative problem by five of the six groups (all except those with alcohol or substance abuse problems). The results of two of the groups that differ most from Table 12 are shown in Tables 29 (for persons with an alcohol or substance abuse problem) and 30 (for persons with a visual impairment).

For the alcohol or substance abuse group (Table 29), four of the top six relative problems are different from those identified by the rest of the respondents (Table 12). All 31 respondents in this group gave CC-19 ("Quality treatment and prevention programs for alcohol and substance abuse are available for adolescents and other young people") the highest importance rating.

The respondents with a visual impairment or deafness identified five different relative problems out of the highest-rated seven relative problems differently than did the respondents as a whole (Table 30, compare Table 12).

Table 29

Respondents who have an alcohol or substance abuse problem, Relative Problems (n=31)

Item	Survey Question	Average Importance	Average Satisfaction	Relative Problem Index
CC-3.	Local media provides education and adequate information for American Indians who have disabilities.	92 (+4)	37* (-2)	76* (+3)
CC-19.	Quality treatment and prevention programs for alcohol and substance abuse are available for adolescents and other young people.°	100* (+8)	45 (-6)	74* (+7)
CC-11.	Affordable health care insurance is available to you.°	95 (+2)	43* (-5)	74* (+4)
CC-17.	Social agencies have outreach services to contact all American Indians in the community who have a disability.	94 (+6)	41* (-8)	74* (+7)
CC-27.	Help (like advocates or legal assistance) is available for solving problems with landlords, employers, utility companies, and others.	95 (+8)	45 (-3)	72* (+5)
CC-2.	The Indian community understands the needs of its members with disabilities.	94 (+3)	47 (-8)	71 (+7)
CC-34.	Adequate career counseling is available to all American Indians who have a disability.°	97* (+6)	50 (+2)	70 (+1)
CC-36.	You know your rights (regarding, for example, housing, employment, social services) as a citizen with a disability.°	95 (+2)	48 (-1)	70 (+1)
CC-15.	Doctors, nurses, and other health service providers have enough knowledge of your culture to provide safe and competent health care to American Indians with disabilities.	94 (+3)	49 (-3)	69 (+3)
All 37 Items, Average		91 (+3)	52 (-3)	66 (+3)
	Standard deviation	5.5	7.5	5.4

Note. "*" indicates more than one standard deviation above or below the average for all 37 items.
Note. Numbers in parenthesis show gain or loss of rating points when compared with ratings by all 150 respondents.
° Also considered a relative problems by all respondents (Table 12).

Table 30

Respondents who have a visual impairment, Relative Problems (n=51)

Item	Survey Question	Average Importance	Average Satisfaction	Relative Problem Index
CC-3.	Local media provides education and adequate information for American Indians who have disabilities.	88	38* (-1)	74* (+1)
CC-22.	Financial assistance is available to students with disabilities who want to attend college or technical school.	93 (+3)	45* (-8)	72* (+7)
CC-19.	Quality treatment and prevention programs for alcohol and substance abuse are available for adolescents and other young people.°	94* (+2)	47 (-4)	71* (+4)
CC-17.	Social agencies have outreach services to contact all American Indians in the community who have a disability.	89 (+1)	47 (-2)	69* (+2)
CC-36.	You know your rights (regarding, for example, housing, employment, social services) as a citizen with a disability.°	92 (-1)	48 (-1)	69*
CC-15.	Doctors, nurses, and other health service providers have enough knowledge of your culture to provide safe and competent health care to American Indians with disabilities.	92 (+1)	50 (-2)	68* (+2)
CC-27.	Help (like advocates or legal assistance) is available for solving problems with landlords, employers, utility companies, and others.	91 (+4)	49 (+1)	68* (+1)
CC-33.	Special programs to help young people with disabilities make the transition from public school to employment and community living are available and adequate.°	88 (-1)	48 (-1)	68* (+1)
CC-11.	Affordable health care insurance is available to you.°	92 (-1)	51 (+3)	67 (-3)
CC-28.	Affordable housing (both private and public) is available and accessible to residents with all types of disabilities.°	89 (-1)	50	67
CC-35.	Assistive devices (such as wheelchairs, braces, hearing aids, and so on) are available and affordable.°	93 (+1)	52 (+3)	67 (-1)
All 37 Items, Average		86 (-2)	54 (-1)	62
	Standard deviation	7.4	7.9	6.0

Note. "*" indicates more than one standard deviation above or below the average for all 37 items.
Note. Numbers in parenthesis show gain or loss of rating points when compared with ratings by all 150 respondents.
° Also considered a relative problem by all 150 respondents (Table 12).

Profile: Newcomers. At least 17 respondents had lived in the metroplex for a year or less. Most of the interviews were held either at the American Indian center in Grand Prairie (n=6) or at the Dallas Intertribal Center (n=6) rather than in their homes. All but one of these interviewees was male, and their average age was 31. This group included a seven-year-old child with a disability, whose mother was interviewed.

Most of them were visiting the metroplex to receive services in treatment programs such as those at the American Indian Center. In response to GI-20, six indicated that they moved to the metroplex to receive treatment for their disability, to receive services (n=3), or to attend an alcohol or drug abuse program (n=2), or to continue their sobriety. Five indicated that they relocated or moved to the metroplex for a job, to work, or just for the "opportunities." Fifteen of the 18 indicated that they had received help to handle problems with alcohol within the past year (SI-9A), and 12 indicated that they had received help to handle problems with drugs within the past year (SI-10A). Twelve also indicated that they were *currently* receiving services from an alcohol or substance abuse counseling program, almost always (10 of 12 times) indicating the American Indian Center as the service provider. Because of these facts, this group identifies many of the same relative problems as those with alcohol or substance abuse problems (Table 26).

Eight indicated that they planned to stay in the metroplex because of the economy or for their job or work (n=5), to change their environment or stay sober (n=2), or because of Indian events and friends (GI-22, 23). Eight others indicated they did not plan to stay in the metroplex, because they wanted to return to homes or families elsewhere (n=4) or because of a job elsewhere or lack of a job in the metroplex. This accounts for some of the out-of-state addresses in Table 1.

The average importance rating given to the consumer concerns by the "Newcomers" was the same as for the other respondents, but the average satisfaction rating was several points less (Table 31). Five of the top nine relative strengths (Table 31) are different from most of the rest of the respondents. In fact, two of them, CC-34 and CC-35, were considered *problems* by the respondents as a whole (Table 12). On the other hand CC-8 ("You are treated fairly by the police and court officials"), an item considered as a strength by most respondents (Table 11) is considered by this group to be the greatest *problem*, due to an extremely low satisfaction rating (Table 32). Half of the relative problems identified by this group are different from those of the respondents as a whole (Table 11).

Table 31

Newcomers, Relative Strengths (n=17)

Item	Survey Question	Average Importance	Average Satisfaction	Relative Strength Index
CC-16.	Doctors and hospitals accept Medicaid and Medicare when you need it.†	97* (+5)	64* (+4)	79* (+5)
CC-20	Alcohol and substance abuse counselors understand your problems and know how to help you.	93 (+11)	64* (+4)	81* (+7)
CC-13.	You can call for and get help in an emergency.†	93 (-4)	63* (-8)	76* (-7)
CC-22.	Financial assistance is available to students with disabilities who want to attend college or technical school.	94 (+4)	60* (+7)	75* (+6)
CC-1.	You can successfully obtain services for your own needs.†	93 (+3)	58 (-6)	74* (-2)
CC-7.	You feel safe in your home and neighborhood.†	94 (-2)	57 (-7)	73 (-5)
CC-23.	Opportunities for adults to learn reading and writing and adequate vocational training or retraining are available.	92	58 (+3)	73 (+2)
CC-34.	Adequate career counseling is available to all American Indians who have a disability.°	92 (+1)	56 (+8)	72 (+6)
CC-35.	Assistive devices (such as wheelchairs, braces hearing aids, and so on) are available and affordable.°	93 (+1)	54 (+5)	71 (+4)
All 37 Items, Average		88	52 (-3)	68 (-1)
	Standard deviation	6.9	7.7	5.7
Dropped from Relative Strengths (partial list):				
CC-8.	You are treated fairly by the police and court officials.†	89 (-1)	31*(-29)	53 (-20)
CC-9.	Health service providers and social agency staff treat with dignity and respect and are sensitive to your disability.†	86 (-6)	58	71 (-6)
CC-25.	Accessible parking spaces (for example handicapped parking) are available and adequate.†	79 (-10)	60* (-7)	69 (-8)
CC-37.	Checkout stand and aisles in stores are safe and accessible for shoppers who have disabilities.†	85 (-7)	53 (-8)	67 (-8)

Note. "*" indicates more than one standard deviation above or below the average for all 37 items.
Note. Numbers in parenthesis show gain or loss of rating points when compared with ratings by all 150 respondents.
† Also considered a relative strength by all 150 respondents (Table 11).
° Also considered a relative problem by all 150 respondents (Table 12).

Table 32

Newcomers, Relative Problems (n=17)

Item	Survey Question	Average Importance	Average Satisfaction	Relative Problem Index
CC-8.	You are treated fairly by the police and court officials.†	89 (-1)	31*(-29)	78*(+18)
CC-3.	Local media provides education and adequate information for American Indians who have disabilities.	90 (+2)	36* (-3)	76* (+3)
CC-19.	Quality treatment and prevention programs for alcohol and substance abuse are available for adolescents and other young people.°	93 (+1)	44* (-7)	72* (+5)
CC-28.	Affordable housing (both private and public) is available and accessible to residents with all types of disabilities.°	89 (-1)	44* (-6)	71* (+4)
CC-11.	Affordable health care insurance is available to you.°	96* (-3)	50 (+2)	69 (-1)
CC-36.	You know your rights (regarding, for example, housing, employment, social services) as a citizen with a disability.	94 (+1)	49	69
CC-27.	Help (like advocates or legal assistance) is available for solving problems with landlords, employers, utility companies, and others.	93 (+6)	49 (+1)	69 (+2)
CC-2.	The Indian community understands the needs of its members with disabilities.	89 (-2)	46 (-9)	69 (+5)
CC-17.	Social agencies have outreach services to contact all American Indians in the community who have a disability.	89 (+1)	47 (-2)	69 (+2)
CC-33.	Special programs to help young people with disabilities make the transition from public school to employment and community living are available and adequate.°	89	47 (-2)	69 (+2)
CC-29.	You are aware of housing assistance services in the community.	93 (+12)	50 (+7)	68
CC-32.	Employment agencies and prospective employers focus on the strengths and abilities, rather than the problems and difficulties, of an applicant with a disability.°	90 (+1)	50 (+4)	67 (-2)
All 37 Items, Average		88	52 (-3)	64
	Standard deviation	6.9	7.7	5.7

Note. "*" indicates more than one standard deviation above or below the average for all 37 items.
Note. Numbers in parenthesis show gain or loss of rating points when compared with ratings by all 150 respondents.
† Also considered a relative strength by all 150 respondents (Table 11).
° Also considered a relative problem by all 150 respondents (Table 12).

DISCUSSION

The Sample

This project interviewed 150 American Indians with disabilities. The cities of Dallas and Fort Worth were well represented, in proportion to the number of American Indians living in those cities. Many of the American Indians have, however, moved to the suburbs in Dallas, Tarrant, and surrounding counties, and their numbers, while represented somewhat, are under represented in comparison with the cities. Analysis of the census information suggests that the American Indian community is dispersing throughout the metroplex, with few noteworthy concentrations.

There were also differences between the AIRRTC survey and the McClure & Taylor survey. They report (1973, Appendix 4) between 75 and 99 interviews in ZIP code 75204 near central Dallas, whereas the AIRRTC survey interviewed only one person giving an address in this area. Table 1 gives a comparison of the two surveys showing the ZIP codes with the largest numbers. However, it is also important to realize that Dallas has almost 200 ZIP code areas. Respondents in the AIRRTC survey give addresses in only 22 of these.

Methodology

The methodology for this project was patterned after previous AIRRTC projects in Denver and Minneapolis. It was also similar, in many respects, to the methodology used in Dallas for the study reported by McClure and Taylor (1973). Community involvement is an essential component of this methodology.

While the methodology for this project worked well in most respects, as it did in the previous surveys in Denver and Minneapolis, there is room for improvement. First, the questionnaire as a whole was too long. As in the previous studies of this kind, the interviews took an average of more than 80 minutes to complete. This strains the patience and endurance of both interviewer and respondent. More work should have been done with the local community to sift and winnow the questions in the sections on general information, disability information, services information, educational information, social information, and employment information to remove unnecessary questions.

Another area where there may be room for improvement is in the process of identifying consumer concerns with the working group of local American Indians with disabilities. The seemingly rigid format for issue statements developed by the University of Kansas has the advantage that it permits easy comparison of the relative importance and satisfaction of each item. This permits issue statements to be ranked in terms of relative strengths and relative problems, which makes it easier to see more clearly the issues needing the most attention by the community. However, a researcher using this method may be perceived by members of the working group of American Indians with disabilities as being more interested in matters of format than in their concerns and therefore vulnerable to being perceived as not listening or caring about their concerns. Barbara Bradford Knowlen (personal communication) has observed that "while this has rarely been a problem with the many surveys done in the general population, it has been brought up as a difficulty in all three of the Indians groups."

Clearly, this is a sensitive issue, and needs to be dealt with in a way that effectively involves consumers not only in developing the interview instrument but in a manner that results in their feeling of sense of ownership in the project, which will help motivate them to organize initiatives to improve services and conditions for Indians with disabilities in the community (Knowlen, personal communication). This sense of ownership by the community is an essential goal of this project.

Results

The process of working on this project in the Dallas–Fort Worth metroplex has already achieved results: More American Indians with disabilities now know more about the services for which they may be eligible, and more have applied for services to the Texas Rehabilitation Commission. The governing board of the American Indian Center in Grand Prairie is considering moving to Tarrant County in order to better meet the needs of American Indians in the Fort Worth–Arlington area, as well as those in Dallas County.

Most of the people we interviewed had lived in the metroplex for at least 10 years, although our survey and the U.S. census show that American Indians are still moving to the area at a steady rate, drawn by services and employment opportunities.

Since many respondents were not familiar with much of the terminology about disabilities used by professionals, it was important to ask for disability information in a number of different ways. While many respondents were familiar with a medical diagnosis for their disability or disabilities, many reported functional limitations covered by the Americans with Disabilities Act but for which they had no diagnostic label. The most common disability was visual impairment (including blindness) or glaucoma (71% of respondents), although few respondents identified that as their primary disability. Most of the respondents also had some kind of orthopedic disorder or functional limitation (61%). Mental or emotional problems (43%), diabetes (38%), and heart problems (35%) were commonplace (Table 3). In fact, most respondents had several disabilities: using the information in Table 3, the respondents had an average of 3.4 disabling conditions each. Most (57%) of the respondents were also using some kind of medication.

Nevertheless, 28% of the respondents did not report receiving medical services in the past year, although this was the service reported by most respondents. The service wanted but not received by the largest number of respondents (33%) was dental care. Although many reasons were given for not receiving dental care, the most common (36%) was that they could not afford the service. The service wanted but not received by the next largest number of respondents (29%) was help to get or keep a job, or training to be able to work. In this case, the most frequently cited barrier to receiving this service was the perception that it was not offered to them (Table 9). In general, the barrier to service most often indicated (Table 9) was that "the services were not offered to me." This may indicate a breakdown in communications. There was some discussion of this issue at the community meetings (Appendix H). As Goodner (1969, p. 14) observed:

> Communication with agencies was especially difficult because these agencies depended upon impersonal channels of communication. To the Indian, this is not only ineffective but often insulting. The head of a branch Social Security office in West Dallas recently said: "I estimate, and it is only an estimate, that there are about 250 Indians in my area [poverty area]. I haven't found the central point where I can go to someone and get things done." The same difficulty became evident in reports from the Department of Labor and the Office of Economic Opportunity. Communicative rigidity on both sides was evidenced by the fact that agencies and civic groups recently avoided the urban Indian hearings in Dallas. Although they were held a block from the Texas Baptist Convention offices, no one attended. Agencies do not typically depend on informal conversation to contact their clients, and Indians do not find help through such cold, formal channels.

Almost half of the respondents (48%) were currently receiving some service from the Dallas Intertribal Center, which offers a variety of services, including an IHS health clinic, JTPA, WIC, etc.

The survey also gathered information of 37 issues identified by a local working group of American Indian consumers. The respondents have given these items an average rating of 88 out of 100, i.e., somewhere between "important" (equivalent to a rating of 75) and "very important" (equivalent to 100). The standard deviation of this importance rating was less than 6, indicating that most of the 37 issues were considered "important," on the average. The *lowest* importance rating for any item was 69, which is between "somewhat important" (5) and "important" (75) on the scale. This indicates that the working group did a good job of identifying issues of importance to this community.

However, the average satisfaction rating for these 37 items was only 55, which is merely "somewhat satisfied" (50) on the scale of satisfaction. The standard deviation was

7.6, which indicates that none of the items was regarded, on the average, as "very satisfactory" (100), and few were even perceived as approaching "satisfactory" (75). In fact, the *highest* average satisfaction rating was only 71 (CC-4 and CC-13). This again indicates that the working group did a good job of identifying issues for which there is much room for improvement.

The strongest positive rating among all issue statements was concerned with emergency assistance (CC-13, Table 11). This item had both the highest importance rating and the highest satisfaction rating. Other relative strengths are listed in Table 11. The greatest problems, relatively speaking, were identified as those issues that ranked above average in importance and below average in satisfaction. The eight most important of these are listed in Table 12, and some of these were discussed at the community meetings (Appendix H.) From these, the greatest needs identified by our survey can be summarized as follows, in descending order of importance:

1. Affordable health care insurance.
2. Employment agencies and prospective employers should focus on the strengths and abilities, rather than the problems and difficulties, of an applicant with a disability.
3. Knowing one's rights as a citizen with a disability.
4. Adequate career counseling.
5. Affordable assistive devices.
6. Quality treatment and prevention programs for alcohol and substance abuse for adolescents and other young people.
7. Affordable housing.
8. Special programs to help young people with disabilities make the transition from public school to employment and community living.

Several issues run through these concerns. One is the issue of affordability (for health care insurance, assistive devices, and housing). Affordability was also the most frequently cited reason for not receiving dental care when needed. This is understandable in that 61% of the respondents indicated that they earned less than $10,000 per year, and 40% earned less than $5,000.

Another is a concern for issues relating to employment (items 2, 3, 4, and 8). Only 45% of the respondents were working for pay, and only 32% were working full-time. Forty-two were looking for a job, and the same number said they were unemployed because of disability. An even larger number (49, 33%) indicated that they, at sometime, had problems finding or keeping a job because of their disability. There was also concern for young people with disabilities (items 6, 8).

Educational Information. Almost one-third of the respondents did not have a high school diploma or GED. On the other hand, more than one-third had had some college or vocational or trade school, but few had a college degree. This indicates a high dropout rate in college. Almost three fourths (73%) of the respondents wanted to increase their education.

Profiles. The analysis subdivided the results according to different groups of respondents. A number of items that ranked above average in importance but near average in satisfaction appear as *relative strengths* in some subgroups but as relative problems in other groups, or vice versa. This often happens when the item is so close to average in satisfaction that a change of a few additional rating points could be enough to classify it as a *relative strength*, which, by definition, is an issue above average in both importance and in satisfaction. Similarly, a drop of a few satisfaction rating points could move it below average enough to classify it as a *relative problem*, which, by definition is an issue above average in importance but below average in satisfaction.

For example, item CC-14 "AIDS education and prevention services are available to American Indians," is considered as a *relative strength* by respondents who are 7 to 21 years of age or who have had some association with the American Indian Center in Grand Prairie, or with the Texas Rehabilitation Commission, who have an alcohol or substance abuse problem, or who live in Tarrant County. However, it is considered a *relative problem* by respondents who have had some association with the Dallas Intertribal Center, or who have diabetes or a visual impairment. Many of these shifts are the result of minor fluctuations in the satisfaction rating; the significance of these shifts is uncertain. For this reason, the tables in the text do not necessarily include every low-ranking item that technically fits the definition of a relative strength or problem.

It is also mathematically possible for an item to have an above average relative strength index *and* an above average relative problem index for the same group. This happens when an item receives a very high importance rating and a near average satisfaction rating. In this situation, whether the item is considered a relative strength or relative problem still depends on whether the satisfaction rating is above or below average. In previous reports, some such items appeared on both the relative strength list and the relative problem list (Marshall, Day-Davila, & Mackin, 1991, pp 31, 32).

Some items that have a very low (or very high) satisfaction rating may not appear on a list of relative problems (or strengths), because the importance rating for the item is average or less than average. For example, item CC-3, which has the lowest satisfaction rating of all 37 items for all 150 respondents, is given an average importance rating, and consequently does not appear on the list of relative problems in Table 12. However, a slight change of a few additional points in the importance rating for this item gives it an important place on the list of relative problems for respondents from Dallas County (Table 14), respondents 21 years of age or less (Table 18), respondents who have had some association with the American Indian Center in Grand Prairie (Table 21), respondents who have a visual impairment (Table 27) or problems with alcohol or substance abuse (Table 26), and newcomers (Table Newcomers B). Item CC-17, for the same reasons, does not appear in Table 12 but appears as an important relative problem among respondents who have an alcohol or substance abuse problem (Table 26) or a visual impairment (Table 27), or who have had some association with the American Indian Center (Table 21) or the Social Security Administration (Table 22), or who are at least 55 years old (Table 19).

Let us now consider individual subgroups. The 26 respondents from Tarrant County were much less satisfied with the understanding of the Indian community about the needs of its members with disabilities than other respondents, and identified this concern as the greatest relative problem (CC-2, Table 16). Other groups of respondents who felt that this misunderstanding by the Indian community was one of the more important relative problems included respondents who had been associated with the Texas Rehabilitation Commission (Table 24) or the Social Security Administration (Table 22). To a lesser extent, respondents with an alcohol or substance abuse problem (Table 26), Newcomers (Table Newcomers B) and respondents at least 55 years old (Table 19) also considered this a relative problem. Also, the Tarrant County respondents were much less satisfied about their ability to successfully obtain services for their own needs (CC-1), which other respondents saw as a *strength*. This may be because there is no Indian Center in Tarrant County at present.

There were 12 respondents age 21 or under. They considered the 37 consumer concerns items "important" (average rating: 78), but not so important as most did other respondents (average rating: 88). This is the lowest average importance rating of all subgroups examined for this report. However, this group was also somewhat more satisfied with these issues than were the rest of the respondents. This suggests that a working group of American Indians with disabilities in this age group might have come up with a somewhat different set of consumer concerns. Their greatest concern (relative problem) was with public transit systems (CC-24, Table 18), which other respondents considered a relative strength (Table 11). They were also much less satisfied with local media as a source of information and education for American Indians who have disabilities (CC-3, Table 18). And like the respondents from Tarrant County, they were not as satisfied with their ability to successfully obtain services for their own needs (CC-1). But like most other respondents, they saw adequate career counseling and affordability and availability of assistive devices as relative problems. Older American Indians with disabilities (age 55 or older, 30 respondents) were most concerned with the affordability and accessibility of housing (CC-28) as the greatest relative problem (Table 19).

There were 24 respondents who had had some contact with the American Indian Center in Grand Prairie. Special problems identified by this group include a lack of satisfaction with: a) information and education provided by local media for American Indians who have disabilities; b) outreach services by social agencies to contact American Indians who have disabilities; c) the availability of help for solving problems with landlords, employers, utility companies, etc.; and d) the services suggested by service providers (Table 21). Respondents who had had contact with the Social Security Administration also were dissatisfied with outreach services. In addition, they were not so satisfied as other respondents that the Indian community understands the needs of its members with disabilities (Table 22).

Recommendations

These results form the basis for a series of recommendations:

1. Representatives of the organizations involved in this project (the Texas Rehabilitation Commission, the Dallas Intertribal Center, the American Indian Center, the Dallas Independent School District, the U.S. Administration on Aging, the Social Security Administration, the Dallas Indian United Methodist Church, and the Fort Worth Indian Baptist Mission) should meet together to formulate a community action plan to develop strategies to meet the needs of the American Indians with disabilities.

2. The availability of general dental services at the Dallas Intertribal Center could be more effectively publicized. A special brochure and a public radio announcement about this service might help. Ways to help pay for outside dental laboratory costs could be explored to enhance the affordability of this service.

3. Employment services offered by the Dallas Intertribal Center and the Texas Rehabilitation Commission should be coordinated and publicized more effectively. The Texas Rehabilitation Commission could consider housing a VR counselor on a regular schedule at the Dallas Intertribal Center.

4. There is a need for an Indian center to coordinate services for American Indians in Tarrant County. There are more than 5,500 American Indians in that county, and for many, the Dallas Intertribal Center is too far away. Although such a center might not be able to provide as many services as does the Dallas Intertribal Center, it might be able to provide some of the most commonly needed services. It could also provide a shuttle service to places

that can provide specialized services and to the Dallas Intertribal Center if services are not available at Tarrant County.

5. There is a need for services specifically targeted for young American Indians with disabilities, especially in the areas of (a) information and referral services, (b) quality treatment and prevention programs for alcohol and substance abuse, (c) career counseling, (d) special programs to help them make the transition from public school to employment and community living, and (e) improving the safety and accessibility of public transit systems.

6. There should be a greater utilization of American Indian media (e.g. Indian programs on radio and TV, newsletters, newspapers, information tables and announcements at pow wows, etc.) to provide more education and information about disability issues in the American Indian community, especially in Dallas. Some issues needing attention include the rights of a citizen with a disability and how to get help for solving problems with landlords, utility companies, and others, etc.

7. Improvements are needed in the availability and affordability of assistive devices. Information tables about this should be set up at pow wows and staffed by an American Indian with sufficient training to answer questions and make appropriate referrals. Loaner programs could be developed with medical supply vendors, programs for special disability groups (such as the Multiple Sclerosis Society), medical rehabilitation facilities, and the Texas Rehabilitation Commission.

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Appendix A

Job Description for On-site Research Coordinator

American Indian Rehabilitation
Research and Training Center
NORTHERN ARIZONA UNIVERSITY
INSTITUTE FOR HUMAN DEVELOPMENT
ARIZONA UNIVERSITY AFFILIATED PROGRAM
P. O. Box 5630
Flagstaff, AZ 86011-5630
(602) 523-4791

JOB DESCRIPTION

TITLE: **Office Assistant, Senior** (On-site Research Coordinator for AIRRTC Project R-28: *The Replication of a Model for Determining Community-Based Needs of American Indians with Disabilities through Consumer Involvement in Community Planning and Change*)

PRIME FUNCTION

Under the supervision of Dr. Robert Schacht, performs work of considerable difficulty in directing or performing a wide variety of standard and specialized tasks on a research project.

DUTIES AND RESPONSIBILITIES

A. **Training Tasks**

1. Assists with **Interviewer Training** as needed.
2. Provides supplementary training to interviewers as needed.

B. **Supervisory**

1. Under supervision, performs specific tasks related to investigating the needs of American Indians with disabilities in the Dallas metropolitan area, e.g. assignment of interviewees to interviewers.
2. Assists interviewers in scheduling appointments with interviewees (individuals with disabilities or family members).
3. Assists with monitoring interviews (including the observation of at least one interview by each interviewer), verification of interviews, and the supervision of interviewers to ensure their professional conduct.
4. Assists the interviewers in submittal of project paperwork, e.g., invoices for payment.

C. Other Tasks

1. Will collect and compile information, brochures, pamphlets and other information regarding resources and services available to American Indians with disabilities in the Dallas area.
2. Maintains close communication with the Principal Investigator, Dr. Robert Schacht, and relays immediately any difficulty relative to the interviews or any other related issues.
3. Works with planing group to revise survey instrument.
4. When no other interviewer can carry through on a given interview, will complete the interview.
5. Assists in the analysis of survey data and community response to preliminary results.

KNOWLEDGE AND SKILLS

Considerable knowledge and/or experience in working with American Indians
Skill in effective interpersonal relations
Skill in written and verbal communication
Supervisory and monitoring skills

MINIMUM QUALIFICATIONS

Bachelor's degree in area related to field of work OR four years related experience
Considerable experience in working with American Indians is preferred.
Knowledge and/or experience in research methods and techniques is preferred.
Knowledge and/or experience in working with persons with disabilities is preferred.

HOURS

Full time, 10/1/91 - 1/31/92; part time, 2/1/92 - 6/1/92

SALARY RANGE

$7.13 - $9.04 per hour

WORKSITE

Dallas, Texas

For more information, contact:
Dr. Robert M. Schacht
AIRRTC
P. O. Box 5630
Northern Arizona University
Flagstaff, AZ 86011-5630
(602) 523-4791

Appendix B

Correspondence for Initial Meetings

DALLAS INTER-TRIBAL CENTER, INC.
209 E. Jefferson, Dallas, Texas 75203-2690
(214) 941-1050 Metro 263-0313

September 6, 1991

Dear Indian Community Member,

We have been asked to coordinate with the Texas Rehabilitation Commission and the Northern Arizona University a needs assessment study for the Dallas/Fort Worth metroplex Indian community. This survey has been conducted in Denver, Colorado and Minneapolis, Minnesota. The purpose of this survey is to identify the needs of the Indian community with an emphasis on those who have disabilities. The purpose of the meeting is to discuss issues identified in the survey, plans ways to improve the community and present this information to decision makers and service providers in order to expand and improve services.

We would like to have your help in developing this survey, and ask that you attend our planning meeting.

Monday, September 30, 1991
7 p.m. to 9 p.m.

Dallas Inter-tribal Center
Conference Room

209 East Jefferson

Refreshments provided

This is a good opportunity for the community to come together and discuss issues and plan for the future of this community. We look forward to working with you.

Sincerely,

Mary Helen Deer Smith

Mary Helen Deer Smith
Executive Director

Serving the metroplex American Indian community since 1971.

DALLAS INTER-TRIBAL CENTER, INC.
209 E. Jefferson, Dallas, Texas 75203-2690
(214) 941-1050 Metro 263-0313

October 31, 1991

Dear Friends:

The American Indian Rehabilitation Research and Training at Northern Arizona University, in cooperation with the Dallas Inter-tribal Center, the American Indian Center, and the Texas Rehabilitation Commission, will be conducting a survey of American Indians who have disabilities in the Dallas - Fort Worth area. The purpose of this survey is to assist American Indians with disabilities in (1) Identifying both the strong points and the problems in their community, (2) organizing to discuss issues identified in the survey, (3) planning ways to improve the community for its American Indian citizens with disabilities, and (4) presenting this information to decision makers and service providers.

We would like your help in developing this survey, and ask that you attend our planning meeting. Also, we would like to hire 10 interviewers for the research project. The interviewer positions will be explained in greater detail at the meeting. We ask all participants to bring a covered dish so that we may have dinner together.

WEDNESDAY, NOVEMBER 13, 1991

10:00 A.M.

DALLAS INTER-TRIBAL CENTER
209 E. Jefferson Boulevard
Dallas, TX 75203-2690

POT-LUCK DINNER

Please think of issues related to your own experience with disabilities--both positive and negative--and plan to share these issues with the group. We look forward to working with you!

Sincerely,

Ron Hickman

Ron Hickman
On-site Coordinator

RH:hl

BEST COPY AVAILABLE

Appendix C

Interviewer Job Description

American Indian Rehabilitation
Research and Training Center
NORTHERN ARIZONA UNIVERSITY
INSTITUTE FOR HUMAN DEVELOPMENT
ARIZONA UNIVERSITY AFFILIATED PROGRAM
P. O. Box 5630
Flagstaff, AZ 86011-5630
1-800-553-0714

INTERVIEWER JOB DESCRIPTION

TITLE: **Interviewer/American Indian Rehabilitation Research and Training Center** (Project R-28: *The Replication of a Model for Determining Community-Based Needs of American Indians with Disabilities through Consumer Involvement in Community Planning and Change)*

EXAMPLES OF DUTIES AND RESPONSIBILITIES

1. Contacts all assigned interviewees (persons being interviewed) prior to interview, explains the purpose of the interview, and makes appointments for interviews.
2. Obtains signature on **Informed Consent Form** of person to be interviewed.
3. Checks completed questionnaires for clarity of recorded responses.
4. Keeps a record of all contacts, interviews completed, and mileage on **Contact Log.**
5. Mails completed **Consumer Interview** and **Interviewee Billing Statement** to supervisor on schedule.
6. Informs supervisor **immediately** of any problems related to the project.
7. Submits **Interviewer Billing Form** and **Contact Log** to supervisor to receive payment.
8. Re-contacts inteviewees just prior to public meeting ro remind them to attend meeting

KNOWLEDGE AND SKILLS

1. Has knowledge of values and communication styles of the various American Indian tribes represented in the Dallas-Ft. Worth area.
2. Can demonstrate making and keeping appointments and meeting deadlines.
3. Has some skill in written and verbal communication.

MINIMUM QUALIFICATIONS

1. Has or can access reliable transportation.
2. Can attend 3-day training scheduled for

WORKSITE

Dallas, Texas

For more information, contact:

Robert M. Schacht, Ph.D.
1-800-553-0714

Appendix D

Recruitment Flyer

American Indians with Disabilities Community Needs Assessment

Dallas - Ft. Worth
January-February 1992

Purpose	To understand the needs and concerns of American Indians in Dallas - Ft. Worth who have disabilities.
Procedure	American Indians with disabilities will be asked to participate in an interview that should take approximately two hours.
Voluntary	You may refuse to answer any questions or stop the interview at any time.
Compensation	You will receive $20.00 for completing the interview.
Benefits	Improved service delivery to American Indians in Dallas - Ft. Worth who have disabilities.

For more information, contact:

Robert M. Schacht, Ph.D.
American Indian Rehabilitation
Research and Training Center
P. O. Box 5630
Flagstaff, AZ 86011-5630
1-800-553-0714

In Dallas - Ft. Worth
Ronald Hickman
Dallas Inter Tribal Center
209 E. Jefferson Blvd
Dallas, TX 75203
(214) 941-1050

Appendix E

Pilot Test Interviewer Training Agenda

12/19/91

INTERVIEW TRAINING SCHEDULE
American Indian Rehabilitation Research and Training Center,
Northern Arizona University, Flagstaff, AZ

Pilot Survey Training, December 16 - 18, 1991
American Indians with Disabilities
Community Needs Assessment, Dallas - Ft. Worth, Texas

[Note: IM = Interviewer Manual; CM = Consumer Interview booklet]

Monday, December 16

8:30 - 9:00 Tour of IHD

Large Conference Room:

9:00 - 9:10 Welcome to AIRRTC — Tim Thomason, Director

9:10 - 9:30 Overview of Denver & Minneapolis projects
Catherine A. Marshall
Co-Director of Research

9:30 -10:00 Overview of Training & Training Materials (IM:1-4)
Robert M. Schacht
Co-Director of Research

10:00-10:15 BREAK

10:15 - 10:30 Definitions (IM:40-41) — Robert M. Schacht

10:30 - 12:00 Consumer Interview: General Information & Disability Information (IM:21-23 & CI:1-5)
[Begin role playing]

12:00 - 1:00 LUNCH

Small Conference Room:

1:00 - 2:00 Services Information (IM:24 & CI:6-11)
[Continue role playing]

2:00 - 2:30 Rehabilitation Services — Priscilla Sanderson
Vocational Rehabilitation Counselor

2:30 - 3:15 Culturally Sensitive Interviewing Strategies
Priscilla Sanderson

3:15 - 3:30 BREAK

3:30 - 4:30 Consumer Concerns (IM:24; CI:12-16)
[Continue role playing]

4:30 - 5:00 Questions & Answers — Catherine A. Marshall

12/19/91

Tuesday, December 17 (Small conference room)

8:30 - 10:00	Educational, Social & Employment Information (IM:24-26; CI:17-24) [Continue role playing]	
10:00 - 10:15	BREAK	
10:15 - 12:00	Interviewer Skills (IM:4-8,16-19,27-31)	
12:00 - 1:00	LUNCH	
1:00 - 1:30	Review of Interview Manual & Consumer Interview	
1:30 - 3:30	First Practice Interview [with Marie Johnson, an elderly Navajo woman with an orthopedic disability, at her home]	
3:30 - 3:45	BREAK	
3:45 - 4:30	Discussion about first practice interview	
4:30 - 5:00	Questions & Answers	Catherine A. Marshall

Wednesday, December 18 (small conference room)

8:30 - 9:00	Discussion about first practice interview, continued	
9:00 - 10:15	Second practice interview (videotaped) (Trainee A interviews Franklin Halwood, a quadraplegic, while others observe)	
10:15 - 10:30	BREAK	
10:30 - 11:45	Second practice interview, continued (videotaped) (Trainee B interviews Franklin Halwood while others observe)	
11:45 - 12:00	Critique of videotaped interviews	
12:00 - 1:00	LUNCH	
1:00 - 2:00	Critique of videos, continued	
2:00 - 3:00	Record Keeping (IM:5,6,32-38; CI:1,24)	Robert M. Schacht
3:00 - 3:15	BREAK	
3:15 - 4:30	Arranging the Interviews (IM:10-15)	Robert M. Schacht
4:30 - 5:00	Final Questions & Answers	Catherine A. Marshall

Appendix F

Definitions Handout

The Americans with Disabilities Act (ADA) defines an "individual with a disability" as a person who has a physical or mental impairment that substantially limits one or more major life activities, a record of such an impairment, or is regarded as having such an impairment.

The first part of the definition makes clear that the ADA applies to persons who have substantial, as distinct from minor, impairments, and that these must be impairments that limit major life activities such as seeing, hearing, speaking, walking, breathing, performing manual tasks, learning, caring for oneself, and working. An individual with epilepsy, paralysis, a substantial hearing or visual impairment, mental retardation, or a learning disability would be covered, but an individual with a minor, nonchronic condition of short duration, such as a sprain, infection, or broken limb, generally would not be covered.

The second part of the definition would include, for example, a person with a history of cancer that is currently in remission or a person with a history of mental illness.

The third part of the definition protects individuals who are regarded and treated as though they have a substantial limiting disability, even though they may not have such an impairment. For example, this provision would protect a severely disfigured qualified individual from being denied employment because an employer feared the "negative reactions" of others.

(From *The Americans with Disabilities Act: Questions and Answers*,
U.S. Department of Justice, Civil Rights Division,
Office on the Americans with Disabilities Act)

The question of whether a person has a disability should be assessed without regard to the availability of mitigating measures, such as reasonable modifications or auxiliary aids and services. For example, a person with hearing loss is substantially limited in the major life activity of hearing, even though the loss may be improved through the use of a hearing aid. Likewise, persons with impairments such as epilepsy or diabetes, that substantially limit a major life activity, are covered under the first part of the definition of disability, even if the effects of the impairment are controlled by medication. (Federal Register 56 #144, 7/26/91)

Appendix G

Concerns Report Survey Results in Order of Average Satisfaction

American Indian
Community Concerns Report
Dallas/Fort Worth Area

N=150

CONCERNS REPORT SURVEY RESULTS IN ORDER OF AVERAGE SATISFACTION

Item	SURVEY QUESTION	AVERAGE SATISFACTION	AVERAGE IMPORTANCE
3	Local media provides education and adequate information for American Indians who have disabilities.	39%	88%
29	You are aware of housing assistance services in the community.	43%	81%
32	Employment agencies and prospective employers focus on the strengths and abilities, rather than the problems and difficulties of an applicant with a disability.	46%	89%
11	Affordable health care insurance is available to you.	48%	93%
34	Adequate career counseling is available to all American Indians who have a disability.	48%	91%
27	Help (like advocates or legal assistance) is available for solving problems with landlords, employers, utility companies, and others.	48%	87%
36	You know your rights (regarding, for example, housing, employment, social services) as a citizen with a disability.	49%	93%
35	Assistive devices (such as wheelchairs, braces. hearing aids, and so on) are available and affordable.	49%	92%
33	Special programs to help young people with disabilities make the transition from public school to employment and community living are available and adequate.	49%	89%
17	Social agencies have outreach services to contact all American Indians in the community who have a disability.	49%	88%

Item	SURVEY QUESTION	AVERAGE SATISFACTION	AVERAGE IMPORTANCE
28	Affordable housing (both private and public) is available and accessible to residents with all types of disabilities.	50%	90%
19	Quality treatment and prevention programs for alcohol and substance abuse are available for adolescents and other young people.	51%	92%
6	Streets and sidewalks in areas of public housing are safe and accessible.	51%	84%
15	Doctors, nurses, and other health service providers have enough knowledge of your culture to provide safe and competent health care to American Indians with disabilities.	52%	91%
22	Financial assistance is available to students with disabilities who want to attend college or technical school.	53%	90%
30	You can get respite care or attendant care from an agency for a family member with a disability.	53%	80%
21	You can meet with other persons or support groups with similar disabilities to discuss and solve problems.	54%	77%
12	Home health care and housekeeping assistance that you can afford is available.	54%	68%
23	Opportunities for adults to learn reading and writing and adequate vocational training or retraining are available.	55%	92%
2	The Indian community understands the needs of its members with disabilities.	55%	91%
14	AIDS education and prevention services are available to American Indians.	55%	89%
31	Assistance in family related issues is available to you and your family.	55%	81%
10	Health care providers skilled in sign language are available to American Indians who are deaf.	55%	79%

Item	SURVEY QUESTION	AVERAGE SATISFACTION	AVERAGE IMPORTANCE
24	Public transit systems (such as buses and cabs) are safe and people with disabilities can get in and out without difficulty.	58%	90%
18	You can trust service providers to suggest the right services for you and your family.	59%	88%
16	Doctors and hospitals accept Medicaid and Medicare when you need it.	60%	92%
8	You are treated fairly by the police and court officials.	60%	90%
20	Alcohol and substance abuse counselors understand your problems and know how to help you.	60%	82%
37	Checkout stands and aisles in stores are safe and accessible for shoppers who have disabilities.	61%	92%
7	You feel safe in your home and neighborhood.	64%	96%
9	Health service providers and social agency staff treat you with dignity and respect and are sensitive to your disability.	64%	92%
1	You can successfully obtain services for your own needs.	64%	90%
5	American Indian cultural and social events, educational programs, and religious services are barrier-free and accessible (including restrooms).	65%	86%
25	Accessible parking spaces (for example, handicapped parking) are available and adequate.	67%	89%
26	Affordable transportation services are available as needed.	67%	87%
13	You can call for and get help in an emergency.	71%	97%
4	You are not isolated from your friends and neighbors because of your disability.	71%	80%

Appendix H

Excerpts from the Community Meetings

Fort Worth Community Meeting
July 24, 1992

EXCERPT 1

Interviewer #1: …I don't think there is too many people that are aware of that. And there's so many other things that Social Services is available, but there seems to be some kind of Indian pride that they will not go. They've been turned down, they have bad help from Social Services, and I run into a lot of them saying I won't go back to that. But they want something that's connected with the Indians, so somebody will be a speaker, somebody will help them. but they don't want a… it's kind of like walking up against a brick wall. If they have to do it themselves, if a white person, a black person or someone else, it's no— they leave. And there was one that had dental problems and he got turned down, and he says I'll not go back there again. And he needs dental care.

EXCERPT 2

Speaker 1: Yes, the process that you have to go through to sign on a form in order to qualify is very degrading so by the time you get halfway through it you decide this is not worth it and their attitude towards you is belittling so you say I'd rather hurt than go through this…
…You have to bring your records with you to prove, you know…

Speaker 2: …that part you can understand, but um, you may spend an hour filling out forms. And by the time they get— then you wait for hours– and it's like your time is not important.

Interviewer #1: I also found that financially did not get around. I mean they had to save what money they have to feed their family. And they do not have transportation.

A short time later:
Speaker 3: [inaudible] …depending on where you go—you talk to so–and–so, oh you have to talk to so–and–so, oh, you talk to so–and–so, so–and–so doesn't know it so they send you back to so–and–so, so–and-so does thing and send you back to so–and–so…

Bob S: So you get the feeling you're getting the run around?

Speaker 3: Yes.

EXCERPT 3

Speaker 1: Well, I know with us in the past when she was talking about Choctaw Indian problem, uh, comprehension and really understanding what someone is saying to you— sometimes you misinterpret and like when we're talking to his doctor, his doctor doesn't always listen to what he is saying. And— or when his doctor is talking back to him. He doesn't always understand—the comprehension part as far as understanding you know, the communication like she was saying is very important that you have someone that can talk to them where they'll understand.

Doctors don't always listen to— especially if they're very [inaudible] surgeons, they don't always listen to their patients...

A short time later:

Interviewer #1: We had a clinic over here on Roosevelt, which is in the Black/Hispanic area. When you go this tri–ethnic center, we had an office there for our clinic. There's nothing but Blacks there. And you have to go after five or six until eight o'clock— you come out of there and you don't know if you going to get knocked in the head or what I mean they're just all lined up. And so the Indian people started pulling away. Then we had a white lady that was the receptionist and she was being rude and cruel to the Indian people. So the clinic was moved back to Dallas. Because people quit participating here in Fort Worth.

EXCERPT 4

Interviewer #2: Well I'm not [Interviewer #1], and that's for sure. [Interviewer #1] can make friends with a door, me I'm a little bit— I still got a lot Indian in me. But, uh, I had a lot of really good people. And most of the people I interviewed were recovering alcoholics and drug addicts. And I , well , I've been around alcohol, my husband died from alcohol. So that wasn't a big deal for me. Then I met some people were in wheelchairs, you know, and that really hit home because here's these people— they're so happy, you know. And here, you know, we can walk and everything and all and still gripe. I interviewed one young man, and I really had a good time. We just sat there after the interview was over and we just talked and laughed and act silly, I mean it was part Indian you know, and so Indians— we act silly with each other. So when we were doing the interviews, calling around, a lot of them we would find out when you ask if they have any disabilities, they'll say no. Because they expect people in a wheelchair aren't crippled or whatever. And when we were really doing the interview, you know, here was a big list. And we'd find out, well hey, my eye sight is bad, you know— have back problems... And you'll come up— one thing you're going for— you're going to find out they have a few more ailments.

Dallas Community Meeting
July 25, 1992

EXCERPT 1

Speaker 1: There's a lot of , um, that I've seen come across my desk , about American Disabilities Act, and on training employers and things like that, and I've seen some things on television that seems like Indians can see it. And they'll say, they saw this, and they'll say that's great, but what about us?

Bob: Yeah.

Speaker 1: Even though they see disabilities, it's for others.

EXCERPT 2

following a discussion of consumer concerns identified as relative problems, re CC-35:

Speaker 1: On the assistive devices, I know when I worked in Oklahoma it was a big thing who's gonna pay for it. And we had a community health fair and we bought two wheelchairs for a clinic. People coming in and that sort of thing. And we bought two wheelchairs for the clinic and [inaudible] health fairs had a client and she just got out of the hospital and she needed a wheelchair, can we loan her ours until PHS can get to it. And it really was against the rules, but she begged us and so OK. Well, PHS found out we gave her a wheelchair and we didn't provide–we didn't give her a wheelchair, it came out of our budget, so I ended up having to – IHS was good enough to let me write it off. Actually, you know, I mean, so there is those kind of territorial things you know like some agencies wait for somebody else to do it first, in the meantime you have a client caught in the crossfire doing without. Because they can't make up their mind that OK you will do it. So I'm surprised that the satisfaction is as high as 49.

EXCERPT 3

following a discussion of difficulties interviewers had finding interviewer's homes:

Speaker 1: I understand all those, but I was one of those victims of being delayed and I was waiting for two appointments and one tentative appointment and it went on for almost a month. So, I, what I was going to say, in returning to the seriousness of the project, how can the center or since your designing your work, how can the center or some advocate help individuals receive their benefits and uh, you know, because a lot of times we sent out all our forms but maybe we are missing something that maybe someone knows who can help us write up our applications so we won't be denied…

A short time later:

Speaker 1: I'm not looking out for myself, I'm looking out for all the others, you know, and they should be – it should be announced that there could be an additional services that you can do to help those people. Because everyone knows a lot of Indians and when they get turned away or they get denied they always just pull back. So we need some support there to try to help them get some of the benefits.

EXCERPT 4

responding to counselor who works primarily with substance abuse:

Speaker 1: Would there be any list of all those other disabilities that are listed? I know for several people they have like [respiratory syndrome ?] and Greys disease and all those other conditions. Is there a list of those?

Speaker 2: Well…any disability [interrupted] would qualify.

Bob: The report will have a more complete listing of all the secondary disabilities as well as the primary disabilities.

EXCERPT 5

Ron: Peggy, do you think that this uh, survey should have focused a lot on the youth, the kids at school?

Peggy: Well, in the DISD, they are classified under special education. Now I did get a printout we had about 15 students from elementary to the secondary. But it didn't give what their disabilities were. And I know two of them are into, you know, home bound. One is a comatosis type of situation. The few parents I did talk to, of course the first thing they want to know is what they can get out of this. I told them right now we are just doing a survey and eventually something will come from this. And I know one time that you were very instrumental when I had a request from another school district, I called on you as a referral and you were able to handle that. I appreciate that cause, you know, we are just learning about disability. But the case manager I had talked to in special education was interested in anything that they could do to help out, especially for the Indian kids, and of course the first thing they said is what can you all do for us. As I told you, we're just doing a survey right now so I wasn't sure what all could be available.

Ron: Of the surveys that most people were interviewed were adults. Do you feel that should have included more younger people in that?

Peggy: Well, in our school, in our newsletter I did put an article in there in reference to this survey being done, and that it was available to all of the parents of children in DISD and to contact you directly, so they were aware of this. Of course a lot of our Indian parents don't go asking either until somebody approaches them, then they open up readily. So that might have been another approach. As far as students, they are a very small percentage, but we do have about 15 that consider under special education. That covers various levels.

EXCERPT 6

Male speaker 1: I want to address the health insurance. Because a lot of people are underemployed or don't make enough money to afford health insurance or uh, somebody that is unemployed. [inaudible]

Ron: You know, I know [??] talks to people who went back to Oklahoma cause they didn't have any health insurance. And one guy had to go get open heart surgery, he went all the way back to Ada, Oklahoma because he couldn't get it here. So health insurance is a big problem too. Some how, I don't know how– I don't know that much about it or how to resolve it. That's a big question too. If anybody knows anything about health, we 'd like to speak with them.

EXCERPT 7

Speaker 1 (Joy): Uh, one of the things that is a concern of mine, and I don't know what solution, you know, I don't know how that this need could be met, but there is quite a population of homeless over in east Dallas that I know of, and I'm sure there is some somewhere else.

Speaker 2: In just your [inaudible] not in just east Dallas.

Speaker 1: Well, on Industrial at Commerce, but over on Gaston Avenue specifically on Gaston Avenue there are a lot of homeless over there, and it really tugs at my heart to see them out there and this is something that needs to be done, this is something that needs to be taken care of. But I don't know how to, I don't know what can be done or who can do something…

EXCERPT 8

Peggy: A young family just had a child that's born with Down's syndrome. Is that considered a disability?

Speaker 1: Yes.

Peggy: Then what can I tell the parents. This is their third child but the first time in their family with anything similar to this.

Ron: Would any counselor want to speak to that?

Speaker 2 (Lori): There should [?] disability contact at this point with Association of Mentally Retarded Citizens and Developmental, uh, I believe it is the Dallas Developmental Center…[inaudible].

EXCERPT 9

Female speaker 1: Is there another way of determining uh, like I have a son with hearing problems, they're not, you know, an individual with [inaudible] or perhaps created by their employment or maybe someone got mugged and got brain damaged. Is there any way you can determine and set those out so we can get a better picture on whether some of these individuals are born with these health as a result of poor nutrition or whatever or as a result of, yeah, trauma. I don't see, I mean I'd like to see something like that.

EXCERPT 10

Peggy: The interviewers that you met with, how many of them utilizes the disabilities services? Did most of them?

Speaker 1: Yes, they did. In fact…

Peggy: So they are pretty knowledgeable then?

Speaker 1: Yeah,.

Speaker 2: In fact some of them are clients now of the TRC as a result of the interview process.

Speaker 3; I think the question was were they participating in a disability related program at the time of the interview.

Speaker 2: No

Speaker 3: It came as a result of the interview.

Speaker 2: Exactly

Speaker 4: No, I'm sorry that's not right because Alex was a client at the time of the interview.

Bob: Well, maybe in that case, but there are other cases in which they weren't before…

Speaker 4; Yeah, but I'm just pointing out that there was one.

Speaker 1: You're right.